PUBLIC HEALTH

LONDON: THE SOCIETY OF MEDICAL OFFICERS OF HEALTH Tavistock House South, Tavistock Square, W.C.1



JUNE-1955

No. 9.-Vol. LXVIII.

MONTHLY PRICE 20. 6d.
ANNUAL SUBSCRIPTION 810. 6d.

Protective Foods

in Infant feeding

The protective foods are known to be important in infant feeding, and certain investigations carried out some years ago demonstrated that a good supply of B vitamins in the ante-natal diet benefited both the mothers and their babies. Marmite yeast extract was used in these experiments and since then it has been recommended to an increasing extent as a source of B vitamins.

Obtainable from Chemists and Grocers Special terms for packs for hospitals, welfare centres and schools

Literature for distribution at welfare centres is available on request from:—

The Medical Department
THE MARMITE FOOD EXTRACT CO. LTD.
Walsingham House,
35 Seething Lane, London, E.C.3.

Marmite can be given to babies from six weeks onwards and in some cases doctors order it to be given from birth. It is often said to be of great value for infants that are not thriving. For babies up to six months a scrape of Marmite on the tip of a spoon can be added to the feed or given in 2 tablespoonfuls of water between feeds.

MARMITE

yeast extract

contains

RIBOFLAVIN (vitamin B_2) 1.5 mg. per oz. NIACIN (nicotinic acid) 16.5 mg. per oz.

Throughout the Country

FAILING LACTATION continues to be replaced by

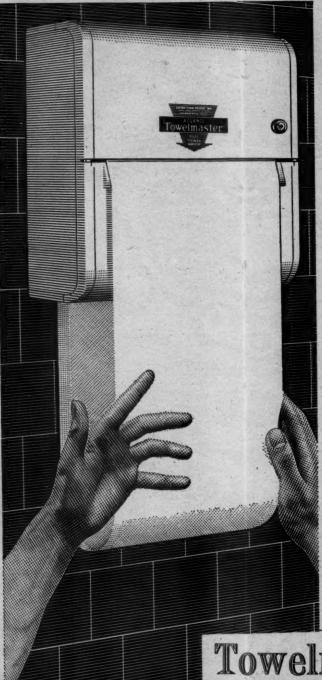
SUCCESSFUL BREASTFEEDING

with the aid of



Samples for clinical trial and specially reduced prices from Infant Welfare Dept., Lactagol Ltd., Mitcham

P.H.5211



A clean soft dry towel for every pair of hands

How does the Towelmaster work?

A pull. Here's a length of laundry-fresh towel, enough and to spare for a really good dry. And as you pull, the used portion automatically winds into a separate compartment of the gleaming white Towelmaster cabinet. Nothing more efficient. Nothing more hygienic.

How much does the Towelmaster cost?

5/- per roll of towelling. Minimum usage only one roll per cabinet per week. Installation is free. Maintenance is free (two or more cabinets). No charges for replacement. In fact there are no other charges whatsoever.

How much is the Towelmaster worth?

Those few shillings give 180 pairs of hands an honest-to-goodness dry. Benefit staff and visitors alike. Give you 45 yards of goodwill. And what an infinitesimal price to pay for a clean bill of health!

What are your particular needs? We'll be glad to discuss them—without obligation.

ADVANCE

Towelmaster

Advance Linen Service Ltd. (Dept. T40). Stratton House, Piccadilly, London, W.1. Telephone: Mayfair 8886.

Under the new Food and Drugs Amendment Act 1954

DEOSAN HAVE THE ANSWER TO ALL CLEANING AND HYGIENE PROBLEMS

Deosan Ltd. were the first firm to specialise in the development and manufacture of specialised products for cleaning and sterilising purposes in the catering industry and allied trades.

With the vast amount of knowledge accumulated from their experience in the field, backed by extensive laboratory tests no one is more qualified to advise you than Deosan.

May we send literature to you or to any "doubtful" establishment in your territory?

To Deosan Limited, Ca	atering Hygiene Division (Dept. P.H), 42-46 Weymouth Street, London, W.1.
Please send me full de	etails of Deosan Products for use in
	Name
	Address

ARE YOU IN THE PICTURE ABOUT FAREX?





FAREX takes baby smoothly onto solids, trains him to accept new flavours and textures



Regular FAREX till schooldays consolidates a good start—gives balanced nourishment, guards against fatigue



In convalescence, the *sustaining* diet is FAREX—valuable especially with gastric cases and dyspeptics



FAREX makes an easily-consumed and satisfying meal for the elderly. So easily-prepared too—needs no cooking



- the versatile 3-cereal food

PUBLIC HEALTH

OFFICIAL JOURNAL OF THE

SOCIETY OF MEDICAL OFFICERS OF HEALTH

Telephone: EUSton 3923 TAVISTOCK HOUSE, TAVISTOCK SQUARE, LONDON, W.C.1 Telegrams: Epidauros, Westcent

No. 9. Vol. LXVIII

JUNE, 1955

CONTENTS

										DIGE		PAGE
	soci	ETY OF	MEDIC	AL OFF	ICERS	OF	HEAL	TH		PAGE	SPECIAL ARTICLES	raus
The May	Council	Meeting								129	Credits and Discredits. By John Riddell, M.D., D.P.H	
District	Nursing	Records								142	Health Education in Practice. By J. D. Kershaw, M.D., D.P.H	
The Orga	anisation	of an C	Occupatio	nal Healt	th Ser	vice	**		**	143	Medical Care of Young Persons in Industry. By J. A. Duncan, M.B., CH.B. Basic Elements in Child Psychiatry. By Kenneth Cameron, M.B.,	
The Plac	e of the	M.O.H.	in Resea	rch :				• • •	• •	145	F.R.C.P.E., D.FSYCH	

THE MAY COUNCIL MEETING

A Meeting of the Council of the Society was held on Friday, May 13th, when 37 members were present. Dr. C. Metcalfe Brown was in the Chair.

Milk and Dairy Regulations .- (A) National Dairymen's Association.—It was reported that members of the Standing Committee for Food Matters had discussed informally with representatives of the National Dairymen's Association the question of the preparation and sale of milk with flavouring matter added. The National Dairymen's Association would like to see the regulations changed so that it would become legally possible for beverages described as flavoured milk to be handled in pasteurising dairies and delivered to housewives in the same way that full-cream milk was at present distributed. 'The National Dairymen's Association had been informed that the Society's view was likely to be that, whether or not the sale and distribution of such beverages was permitted, it should not be described as "flavoured milk" but that an effort should be made to find a name in which the word "milk" was used only as an adjective. The Dairymen's Association was informed that at the appropriate time the Society would no doubt make recommendations to this end to the responsible Ministry and would strongly advocate the adoption of a standard which would safeguard the public from being supplied with an inferior product. The minimum acceptable standard at the present time should be 85% milk.

Another matter discussed at this meeting was the difficulties experienced in some areas in connection with the replacement or repair of recording thermometers on pasteurising plant.

The Council noted the report, and, on the suggestion of the Standing Committee for Food Matters, authority was given for an approach to be made to the Manufacturers' Association concerned to point out the serious difficulty in complying with the Regulations which arose from the present unsatisfactory position with regard to the maintenance of pasteurising plants.

(B) Sterilisation of Milk Vessels.—It was also reported that the Standing Committee for Food Matters had considered a resolution passed at a meeting of the County Medical Officers of Health Group regarding the relative merits of steam and sodium hypochlorite sterilisation. From the resolution of the Group it appeared that they strongly favoured sterilisation by steam in all cases. The Standing Committee for Food Matters, however, did not entirely accept this view, and did not agree that sterilisation by the

use of sodium hypochlorite was unreliable. It was their view that sterilisation by a solution containing 200 parts per million hypochlorite, if undertaken correctly, is effective and bacteriologically gives very good results. It should, however, be followed by a wash using a very much weaker The Standing Committee would accept the suggestion that in all probability average results obtained by steam would be better than average results obtained by the other method, but it would be wrong to condemn the use of hypochlorite, especially as the operation is much easier and also because of the extreme difficulty which might be experienced in country districts in obtaining fuel for the preparation of steam for sterilisation purposes. The County Medical Officers of Health Group had suggested that an investigation should be carried out as to the relative merits of the two methods, but it was the view of the Standing Committee that these were already fully known.

With regard to other recommendations the Committee was of opinion that the question of advising "on-the-spot" tests, to detect the presence of sodium hypochlorite added to milk for keeping purposes and to indicate the available chlorine content in sodium hypochlorite solutions, was a matter for some institute such as the National Institute for Research in Dairying. The Committee, however, did not feel that there was any great need for such tests as samples of milk could be taken under the ordinary procedure laid down in the Food and Drugs Acts, and the Regulations made thereunder, and so far as the suitability of sodium hypochlorite was concerned those solutions recommended for use by the Ministry were known to be satisfactory. If it were found that these solutions were being used those responsible could be reasonably certain that the proper concentration was being applied.

Before dealing with the matter any further the Council decided that the views set out above should be sent to the County Medical Officers of Health Group so that they could give further consideration to this question.

G.R.O. Circular 1/1955.—It was reported that the General Purposes Committee had discussed the implementation of this Circular on the suggestion of Dr. C. B. Crane, M.O.H. County Borough of York. Dr. Crane was of opinion that the operation of the circular would upset the comparative accuracy of infectious diseases returns in all areas and had quoted an example of the difficulties which were likely to occur. It had been pointed out at the General Purposes Committee that the Circular did not do more than follow the requirements of Section 144 of Public Health Act, 1936.

The Act did not specifically require notification of cases occurring in infectious diseases hospitals but Ministry of Health Circulars had asked them to follow the same procedure as other hospitals. From the point of view of indicating the source of an outbreak of infection the notification would be more useful if it went to the area in which the patient was normally resident. After careful consideration it was resolved that the Ministry of Health be asked to consider this question to see if it were possible to overcome certain of the difficulties which had been mentioned.

District Nursing Records.—The Council considered the report of the special Sub-Committee which had been set up to make recommendations regarding a suggested common standard form for recording the work carried out by the district nurse. It was agreed that the attention of all Medical Officers of Health of local authorities be drawn to the suggested common standard, which is set out with full explanations as to its use on page 142 of this issue.

Administration of the Society.—The Council considered the recommendations of the Sub-Committee which had considered the report of the Medical Secretary, and the recommendations regarding the future administration of the Society were adopted.

Centenary Committee.—The Chairman of Council reported briefly on the plans which were being discussed for the celebration of the Society's Centenary. Full details of the plans cannot yet be made public as other organisations are involved, but the Council was very glad indeed to know that a number of bodies had offered to assist the Society in several ways.

Regional Organisation of Tuberculosis Services .- The Council of the Society endorsed a Statement issued after a meeting of medical officers, of various categories, engaged in the Tuberculosis Services, arranged jointly by the Joint Tuberculosis Council and by the Society. The statement was to the effect that more complete co-ordination between various interests in the Tuberculosis Services was particularly necessary at the present time because of the recent alteration in the significance of tuberculosis. The chances of the early eradication of tuberculosis were excellent if an exact integration of all the services was secured. The Joint Committee had given particular attention to an even greater emphasis on preventive measures, and it recommended that, in each Regional Hospital Board area, a Tuberculosis Standing Committee of the Board should be established, upon which would serve representatives of the Medical Officers of Health and of the Chest Physicians in the Region.

Meat Inspection.—It was reported that arrangements had been made for a joint meeting of representatives of the B.M.A., the British Veterinary Association, the Sanitary Inspectors' Association and the Society at an early date.

Industrial Health Advisory Committee.—The Council received the following reply from the Ministry of Labour to its request for the right to nominate a member of the Industrial Health Advisory Committee:—

"I am writing, on the Minister's behalf, in reply to your letter of December 7th last, in which you submitted a request for representation on the Industrial Health

Advisory Committee.

The Minister has given much thought to the composition of the Committee in order to ensure that the membership will cover the industrial, medical, nursing and other aspects of industrial health in a way which will be adequate and also suitably balanced having regard to the Committee's functions and the field within which it is to operate. At the same time, he has found it necessary to limit the number of members to avoid the Committee being unwieldy in size. Although most of the members have been nominated by various organisations, they are being appointed to serve in an individual capacity.

On the above basis, the medical members of the Committee have been nominated by the Royal College of Physicians, the British Medical Association, the

Association of Industrial Medical Officers, the Association of Certifying Factory Surgeons, and, in addition. the Minister has decided to include in the Committee one lay person who is actively concerned in local authority and public health administration. Before deciding upon these appointments, the Minister gave full and sympathetic consideration to your and other requests for membership and he regrets that he does not feel able to add to the number of members to be appointed from the medical profession, or from the local authority field. He asks me to say that he would value the co-operation of your Society from time to time in the examination of particular problems or local developments with which you may be particularly concerned and I hope therefore that I may communicate with you again when any such matters arise.'

In spite of this lack of success the Council was grateful to the B.M.A. for the efforts that had been made on the part of the Society to secure representation, and with this in mind the Council decided again to seek the assistance of

the B.M.A. in this matter.

It was thought that the B.M.A. might agree to press for a third representative on the Advisory Committee, and that failing such an approach they might reconsider the representation already determined, to secure that at least one member of the Advisory Council was a member of the Public Health Service.

Occupational Health.—The Occupational Health Com-

mittee presented a draft statement of policy for the approval of the Council. In accepting and endorsing the memorandum the Council thanked the members of the Occupational Health Committee for their work in this connection. The document is published elsewhere in this issue of PUBLIC HEALTH (page 143).

Research Committee.—The Research Committee also presented a report and the members of the Committee, and in particular Professor F. Grundy were thanked for their work in connection with its preparation. The Council adopted this report and authorised its publication in Public

HEALTH (see page 145).

Visiting of Children in Infectious Diseases Hospitals.—It was reported that a letter had been received from the Secretary of the Standing Medical Advisory Committee seeking the advice of the Society on the question of the daily visiting of children in infectious diseases hospitals by their parents, under adequate safeguards against the introduction or spread of infection. The action of the Chairman in dealing with this question as a matter of urgency was endorsed, and the following reply (drawn up with the assistance of the Fever Group) and sent to the Advisory Committee, was confirmed:—

"In accordance with the request of the Standing Medical Advisory Committee, the Society of Medical Officers of Health have considered the question of the visiting of children in infectious diseases hospitals, with particular reference to the necessary precautions and the

following are their observations:-

1. The Society is in favour of the principle of allowing parents to visit their children in isolation hospitals as frequently as is prudently possible and daily in suitable cases and under suitable circumstances. It is felt that prolonged separation of parent and child may have adverse psychological effects on the child in some cases.

2. A principal function of infectious diseases hospitals is the protection of the community by preventing or limiting the spread of infection and if this function is to be efficiently performed, it follows that any great increase in visitation must be subject to the application of appropriate safeguards.

3. These safeguards should include the following:

(a) Adequate provision of cubicle accom-

modation.

(b) Adequate nursing staff which would need to be greater in numbers than at present in that close

(Continued on page 148).

CREDITS AND DISCREDITS*

By John Riddell, M.D., D.P.H.

Medical Officer of Health, Midlothian and Peebleshire

County Council.

"O wad some Pow'r the giftie gie us To see oursels as ithers see us! It wad frae monie a blunder free us An' foolish notion"

Less than a month ago speeches were being made all over the world, praising our immortal countryman Robert Burns. The words of my title are taken from his poem "To a Louse," surely an appropriate subject for a public health audience. Apart from this, however, they struck me as being suitable for my Address to-day for another reason. Just a week or so prior to the Burns' orations Prof. T. M. Knox, Principal and Vice-Chancellor of St. Andrew's University, warned medical graduates against the growing tendency to divert professional men from the practice of their profession into administration. He is reported as saying as follows:—

"Administrators have grown so much in popularity that to go in for administration is now generally regarded as promotion instead of the reverse. It used to be said in scorn about teachers, that they taught only because they could not do. One might perhaps have expected an equally scornful remark about administrators. In fact, administration is just a necessary evil, and whatever its difficulties, it is a great deal easier than the exercise of professional skill. I feel fairly confident that the care of patients is a great deal more exacting than the administration of medical services or the Public Health Acts and should therefore stand correspondingly higher in the public esteem."

Professor Knox was previously a Professor of Moral Philosophy, and it may be that the mental exercise required in such a post is not of the kind to keep one in close touch with reality and everyday problems. He makes two main points—the preference for administrative over clinical work, and the easiness of administrative duties compared to clinical responsibility. On both counts, of course, he is completely wrong. The whole outcry in public health for many years now has been that there are insufficient doctors prepared to leave hospital and general practice and take up administrative health work. What clinical specialist would consider it promotion to be appointed an administrative medical superintendent of a hospital? Even in local authority employment, as we are constantly having pointed out to us on the salary negotiating committee, the salaries for assistant and senior medical officers must be sufficiently high to provide "career" grades, because many of the incumbents do not wish to leave the clinical for the administrative field.

And his second point—the easy existence of someone administering the Public Health Acts. I wonder if Prof. Knox has ever considered at all carefully the relative difficulties of the clinician and the administrator. When the clinician is dealing with patients he is concerned with persons who have come to him seeking help. Whether as a general practitioner or as a consultant he is giving them something they have themselves sought, and the benefits of which they can themselves directly appreciate within a measurable space of time. On the other hand the administrator is someone who has to persuade people to do things which in the majority of cases are all against their normal inclinations. He has to persuade his committee or board When the services are provided he has to spend money. to persuade the public to make use of them. No question of dictatorship! Notwithstanding the slur in Prof. Knox's remarks on teachers, it has long been recognised that to be a good teacher of children is an exhausting job. To be a successful persuader of their parents is still more wearing !

But what is behind Prof. Knox's remarks? For we must admit that his views are held by not a few! Why should the public health officer have sunk to this sorry pass—even in the view of the minority? I think it might be worth our while to consider this matter in some detail.

In 1796, Thomas Percival, who took part of his medical course in Edinburgh, reported to the Manchester Board of Health as follows¹:—

"The objects of the Board of Health are three-fold :-

i. To obviate the generation of diseases; ii. To prevent the spreading of them by contagion; iii. To shorten the duration of existing diseases, and to mitigate their evils, by affording the necessary aids and comforts to those who labour under them.

Under the first head are comprehended: The inspection and improvement of the general accommodation of the poor; the prohibition of such habitations as are so close, noisome, or damp, as to be incapable of being rendered tolerably salubrious; the removal of privies placed in improper situations; provision for whitewashing and cleansing the houses of the poor, twice every year; attention to their ventilation, by windows with open casements, etc.; the inspection of cotton-mills or other factories, at stated seasons, with regular returns of the condition, as to health, clothing, appearance, and behaviour of the persons employed in them; of the time allowed for their refreshment at breakfast and dinner; of the number of hours assigned for labour; and of the accommodation of those who are parochial apprentices, or who are not under the immediate direction of their parents or friends; the limitation and regulation of lodging houses, or the establishment of caravanseras for passengers, or those who come to seek employment unrecommended or unknown; the establishment of public warm and cold baths; provision for particular attention to the cleaning of streets which are inhabited by the poor, and for the speedy removal of dunghills, and every species of filth; the diminution, as far as is practicable, of other noxious effluvia, such as those which arise from the workhouses of the fell-monger, the yards of the tanner, and the slaughterhouses of the butcher; the superintendence of the several markets; with a view to the prevention of the sale of putrid flesh, or fish, and of unsound flour, or other vegetable productions.

Under the second general head are included: The speedy removal of those who are attacked with symptoms of fever, from the cotton-mills or factories, to the habitations of their parents or friends, or to commodious houses, which should be set apart for the reception of the sick in the different districts of Manchester; the requisite attentions to preclude unnecessary communications with the sick in the houses wherein they are confined, and to the subsequent cleansing and ventilation of their chambers, bedding and apparel; and the allowance of a sufficient time for perfect recovery, and complete purification of their clothes, before they return to their houses or mix with their companions in labour.

recovery, and complete purification of their clothes, before they return to their homes, or mix with their companions in labour.

Under the third head are comprehended—Medical attendance; the care of nurses and supplies of medicine, wine, appropriate diet, fuel and clothing."

That was 160 years ago. If it were laid down as one of our present-day official "schemes" there is little of our Health and Welfare Services which we would not find authorised. The knowledge of what was and is required has always been there. The difficulty has been its translation into practice.

Almost 90 years ago, John Simon, the first Medical Officer of Health of the City of London, wrote²:—

"The present is a time of the most extraordinary transition and progress in the sciences which are fundamental to medicine; so much so that scarcely a month passes without raising some new pathological question which bears upon principles of action; and this Department, practically considered, would be lagging behind, far behind, the knowledge which ought to be represented in its administration, and might often be spreading mere obsolete error among persons who look to it for intelligence, if it were not itself able to submit such questions to examination, and thus and in other ways take part in the scientific reconstruction which is in progress."

It would seem that not only in recent years have the problems of the administrator been changing with bewildering rapidity. In these present days there is a strong tendency throughout the whole of this land for initiative to be regarded as something "not worth while": for the individual when faced with a problem, to answer "I couldn't care less." Is this the position in the Public Health Service? Might it explain the present outlook towards its officers?

Last autumn the Scottish Branch of the Society was asked to ascertain particulars regarding research work which had been or was being undertaken by Health Departments, or which might be thought to be desirable. The 49 Medical Officers of Health in Scotland were all written to and asked

Presidential Address to the Scottish Branch, Society of M.O.H., February 26th, 1955.

to forward their replies within four weeks. From the replies received it appeared that a considerable amount of research work was being done, or had been done, in 18 of the 49 areas, but it was noteworthy that much of it had apparently not been published. Eight Medical Officers of Health submitted suggestions for research although they had not so far done anything themselves. But after three months two out of every five Medical Officers of Health had still not even replied. Is it a fair assumption that some half of our Medical Officers of Health just couldn't care less? Not a state of affairs to bring credit or respect to the Health

Departments!

At the present time some 20% of the public health staffs in Scotland are not members of this Branch. Similarly, as far as can be ascertained, only about 80% of the Scottish public health staffs are members of the British Medical Association. Some years ago, after the National Health Service came into being, it was agreed that there should be set up a Public Health Service Defence Trust. This was to be financed by a voluntary subscription at the rate of 2s. per £100 of salary per annum from members of the Public Health Service, and the funds were to be used, as required, to maintain or obtain proper salaries and conditions of service for members of the Public Health Service. Similar funds were set up by the general practitioners and hospital staffs. In 1950-51 when we claimed revised salary rates, the matter had to be taken to arbitration. The cost was £1,862 and the money had to come entirely from the funds of the British Medical Association. The amount in the Public Health Fund was negligible. When the case for an increase in Assistant Medical Officers' remuneration went to arbitration in 1953 the cost was about £450 and fortunately in this instance the money in the Public Health Fund was sufficient. We are now launched on a third arbitration. The present state of the Fund for the whole country shows a balance of £2,460—a very small sum if a really serious crisis arose—and even yet only 32% of the Scottish public health staffs subscribe! Less than one in three! What sort of people are we that so many of us are not thoroughly ashamed to "sponge" on our colleagues like this? Is it any wonder if our reputation is not high, not alone as doctors but as ordinary citizens?

Even if we forget our financial indiscretions and consider our work as specialists, either in administrative or in certain branches of clinical medicine, what do we find? Are we really progressive or are the majority only trailing along in

the wake of a few more energetic colleagues?

We set out to educate the public in healthy living. We have clinics for young children and we have regular medical examinations of school children. Are the clinics always examples to the parents of what hygienic premises should be like? In how many schools does medical inspection take place under conditions which make proper examination impossible? How many Medical Officers of Health make it one of their main duties to ensure, not only that the public are shown a good example, but that their staffs are given proper working conditions? How can we expect anyone to believe that we are fit custodians of industrial hygiene when they see such conditions in our own workplaces?

I know of course that the answer of Medical Officers of Health to this is, "But we are doing our best to have these conditions changed." Well, remember the special notice which was thought necessary to safeguard the life of the pianist! He was obviously a poor exponent of his art.

The other excuse we are all very prone to use is that "We haven't the staff." In many cases that the staff is inadequate cannot be denied, but for various reasons it is very doubtful if we ever will have the staff. Because of this we must make it one of our first duties to ensure that we are making the best possible use of existing staff. How many procedures are being carried through and returns made in every department simply because "it has always been done." I would ask every Medical Officer of Health: When did you last make a critical assessment of the results obtained relative to the money, time, and effort expended,

by the various services in your Department? What use do you make of all the information laboriously collected, docketed and filed? Could the services not do with a thorough overhaul and could many man-hours not be saved by elimination of duplication and unnecessary record keeping?

If I might mention a few examples. The vast majority of authorities still carry through a policy of exclusion of school contacts as a routine measure in connection with all the common infectious diseases. A few authorities, for quite a number of years now, have discontinued this and there have been no unfavourable results. Think of the education hours lost unnecessarily. We are increasingly asking our education colleagues to give us more school time for the supervision and treatment of handicapped children. Might we not give them something in return in this way? If we appreciate and help in their difficulties, we will stand more highly in their regard.

In these days, population is moving at an astonishing rate and the age constitution in neighbouring areas is varying immensely both from time to time and from place to place. Do we all examine the case loads of our nursing staff regularly, not only to see that the total number of nurses is adequate, but also that the load of work is evenly divided among them? And where necessary do we make appropriate adjustments?

Matters such as these may appear to be trifles, but it is surprising what results may be achieved when one follows the old Scottish adage about taking care of the pennies.

From a recent investigation³ it appears that first-born children stand a 50% better chance of being immunised against diphtheria by the age of two years than do children in larger families. Child welfare centres clearly play an important part in encouraging immunisation, but the young children in large families are the least likely to be taken there. Surely this is a challenge to the efficiency of the Health Departments that these children—who are at greater risk—should be so neglected.

Further, if we switch to the opposite end of the scale, we again find a disquieting state of affairs. The recent Report by the Ministry of Pensions and National Insurance on the Reasons given for Retiring or Continuing at Work⁴ states:—

"Among every 100 men taking retirement pensions at all ages up to and including 70 some 14 did so because of chronic illness, and a further 29 gave ill-health or strain as the reason for retirement. Men aged 65 who gave ill-health or strain as a reason for retirement had in general more incapacity for work than men giving other reasons for retirement, and men retiring—for whatever reason—tended to have more than men staying on at work. Nevertheless, the figures relating to men aged 65 show"—and this is the important point—" that three out of 10 who said they retired because of ill-health or strain had practically no record of incapacity for work in the whole period of three years and eight months before the enquiry, while in the eight months' period the corresponding proportion was nearly six out of 10. Of the men who retired at age 65 on the grounds of ill-health or strain and who had less than 12 days' incapacity for work in the eight months before the enquiry, 23% consulted their doctor and of these nearly three out of four were advised to retire."

This would appear to be clear evidence that there is a very considerable amount of latent ill-health in the elderly working population which is not shown at all by absence from work.

For the year 1936–37 the average number of days incapacity from sickness among insured persons in Scotland was 14.92.5 Fifteen years later, in 1951, the figure had risen to 22-88.6 Even allowing for the fact that women, and particularly married women, have a higher incidence, and that in 1951 there were more such employed in industry, this in itself is insufficient to explain the increase. If we add to this actual sickness the amount of substandard health as illustrated by the earlier figures I have quoted, we see the immense field which still remains as a challenge to Public Health Workers.

Then, again, there is the question of our "Problem Families." The Secretary of State, as you know, recently

expressed his concern over the bad effects on the health, especially the mental health, of children, which often follows the break up of the family, and has put the responsibility for dealing with this fairly and squarely on the shoulders of the Health Departments. In 1947, following the publication of the Clyde Report,7 Medical Officers of Health stressed that this was the proper procedure but many authorities set up independent children's departments. Have we a record in this connection in the intervening eight years of which we may be proud?

I have to confess that personally I am thoroughly ashamed of the position in my own area. Following on the Secretary of State's circular, I obtained from my health visitors reports on the problem families in their areas. I had, of course, known that there were such families, but the mass of material I received, showing the existence of conditions which would be a disgrace to any civilised community, was appalling. And, I am sorry to say, we did not appear to be making any real effort to assist the health visitors to grapple with this problem. I had got out of touch !

In this connection I would like to say a special word to Assistant Medical Officers. I have mentioned the need for further research and for a critical assessment of existing procedures. Most Medical Officers of Health have, by necessity, to deal with statistics in bulk and with problems which are almost self-evident. To a large extent they are divorced from the day-to-day executive problems and the increasing individual departures from normality which crop up regularly in the work of the Assistant Medical Officers. If a department is to function satisfactorily these matters can only receive adequate attention through the initiative of the Assistant Medical Officers. Without their help and their "drive" the Medical Officer of Health may largely live in a state of blissful ignorance as to improvements which might be effected. Are the Assistant Medical Officers in fact using their initiative? Or are they, as a whole, content to jog along in comfortable little grooves, doing each day's work as it is given to them, taking the easiest way out, and contributing nothing or next to nothing, to the improvement of the service? The Assistant Medical Officers are the foundation of the service. If the foundation is poor, the edifice must surely fall.

This internal unity of effort is only one part of the need of course. As we all know only too well, nothing can produce results like a personal approach. Talks at public meetings or at clinics are all very well but the only place where the people most needing help are to be found, is in their homes. It is the extent of the domiciliary impact which principally makes or mars the success of a Health Department's educational programme. That is why we lay such a great strength on our Health Visiting service. But do our medical staffs have much direct impact in as opposed to on the unsatisfactory home? I feel that it is nothing like so great as it might be. Only too often our staffs are "the clinic doctors." That is wrong! I know the difficulties of course, and undoubtedly we suffer from a bad heredity. But we must realise that the person who should help us in the home is the family doctor. He starts off with the advantage that he is generally "called in." His knowledge of the family background, so essential to the proper treatment of so many of our modern psychosomatic troubles though often not so complete as in past days is still generally extensive. As Edwards, a general practitioner, has said*:

"The popular conception of a general practitioner is of one who heals the sick. He is thought of as being ever ready, day and night, Sundays and weekdays alike, to be called to the home that is stricken by accident or sickness, there to diagnose and treat such cases as he can, or when this is necessary seek the help reasure the anxious, to comfort the bereaved, to set the broken bone, to kill the noxious germ, and to take from an anxious household, on to his own broad shoulders, all responsibility for matters of life and death, joy and sorrow, triumph and disaster.

In such a conception of his functions, the general practitioner's

duties are analogous to those of the fire brigade.

The conception of 'fire brigade' doctoring is even now disappearing. More and more people consult their doctors in order to prevent trouble-to forestall disease and accident. The intelligent layman has access to much information, on the radio, in the Press, even in the cinema, which is rapidly altering his outlook and making him seek to co-operate with his doctor in keeping himself and his family in good health. He is no longer fatalistic about illness, and regards it—not as some demoniacal intervention in his life and work-but as something which should have been foreseen and prevented.

A family doctor should not, primarily, be one who comes hurriedly to the rescue in times of disaster, but a friend and confidential adviser whose job it is to keep families healthy and happy. Although continuing to practise curative medicine for those ailments which doctors are at present unable to prevent, he should seek continually to establish positive health and the prevention

It is our duty to encourage him and co-operate with him. There must be improved liaison not only between the Health Visitor and the General Practitioner but between the Assistant Medical Officer and the General Practitioner. And here again it is a question of personal contact. No amount of correspondence will ever effect the degree of unity of purpose and effort which can be achieved by a personal approach. Assistant Medical Officers and general practitioners must meet one another and be able to speak freely to one another. Medico-political and social contacts readily obtained through British Medical Association membership are invaluable in this respect. I agree that in some cases, an approach will be received, shall we say, without enthusiasm. This should merely serve as a stimulus, an inducement to prove to the general practitioner that combined effort is of value, and should lead to still further attempts. I believe that, at the present time, much of our difficulty arises from the fact that not only the general public but also the general practitioners do not realise how helpful the combined forces of a Health Department may be to them. It is up to us to see that we dispel their misconceptions and enlarge their horizons. The people who should be in the forefront of this work, the people who have infinite opportunity for it, are the Assistant Medical Officers.

I am afraid that by this time all of you may be suffering from one or other of two serious conditions-depression or annoyance. You may feel that I have painted an unduly gloomy, or even an unfair, picture! Well it has been said that the reformer must of necessity take a somewhat narrow approach if he is to stress sufficiently the points which he wishes to drive home. I have deliberately concentrated on a few examples of those matters which, in my opinion, if given adequate attention, would increase immensely the value of our work and raise it not inconsiderably in the estimation of our colleagues and of the general public. I have done so, not in order that I may stand before you as an example of a priggish Medical Officer of Health, but because I feel it to be time these things were said. The freely expressed views of an increasingly enlightened public make it essential that we put and keep our house in order.

That outstanding figure in Public Health-Sir William Savage—no later than three months ago said*:-

"At the moment the Medical Officer of Health is less esteemed than he was, say, a couple of decades ago. I do not believe this old esteem will be re-established unless he can make self-evident that he is much more than an administrator. Actually, of course, he is much more, being an expert on communicable diseases, wise on many subjects with public health facets, acquainted with the statistical appraisement of health progress or retrogression, and with a considerable technical knowledge of environmental This expert knowledge must both be extended and be expressed so that he speaks 'as one having authority' and as a matter of course included in all appropriate discussions.

My views do not seem to have changed with the passage of years and I will end my remarks with a quotation of one brief paragraph from my presidential address to our Society in 1935

on 'Our Future'

'It will be obvious that I do not hold the view that Medical Officers of Health are but passive instruments to carry out policies initiated in Parliament or Whitehall under the direction of their respective authorities. They have this to do but I believe their special training and wide experience entitled them to, and should compel them to, survey the whole sphere of preventive medicine and to express their views and to exert their influence in making the practice of public health more scientific in outlook and more effective in operation.

Let us always remember this. No body of people has any better record of good work done than the staffs of public health departments. No one else can claim to have saved so much misery, so many lives, or so much useless expenditure of money. Our record is one of which to be proud! In 1936 the Committee on Scottish Health Services

"The broad effect of the evidence is to show that the social and economic background has changed so as to allow immeasurably greater possibilities of healthy living for the mass of the people, that the habits of the people from whatever cause or combination of causes—improved sanitation, higher standard of living, more general education, quicker communications, increased and more varied facilities for recreation and so on-are in fact healthier, and that the people as a whole are more ready than formerly to take measures to safeguard and promote their health. No witness, however, suggested that there was not great room for improvement: .

At the present time we are doing valuable work, but if it can be further improved, then we must improve it. is not something for me to do, or for you to do, but for all of us to do. Something for us to do, not in isolation, but in association and joint effort with all our colleagues, medical and lay. Something which, when it is finished, we may look back upon with a feeling of satisfaction knowing that we have done a good job, knowing that we have enhanced the prestige of our service, and knowing that we have added our little quota to the happiness and the well-being of mankind. If we may again return to our National Bard :-

> "Now's the day, and now's the hour; See the front o' battle lour! See approach proud Edward's power-Chains and slavery!

Who will be a traitor knave? Wha can fill a coward's grave? Wha sae base as be a slave? Let him turn and flee!

Lay the proud usurpers low! Tyrants fall in every foe! Liberty's in every blow! Let us do or die!

We are on trial, ladies and gentlemen. On trial at the present time for our very existence! If the accusation is made that "we couldn't care less" let us be in a position to prove, not only by our words, but by our deeds, that it is a lie!

REFERENCES

Percival, Thos. (1796.) The Works, Literary, Moral and Medical, of Thomas Percival, M.D., Vol. 1, p. cclvii et seq.
 Simon, John. (1868.) Tenth Report of the Medical Officer

of the Privy Council, London, p. 18.

Boundary of the Institute of Child Health (Univ. Lond.). Society of Medical Officers of Health and Population Investigation Committee. (1954.) Health and Growth of the Under-Fives, p. 16.

Ministry of Pensions and National Insurance. (1954.) Reasons

given for Retiring or Continuing at Work. Report p. 16.

Department of Health for Scotland. (1939.) Seventh Report on Incapacitating Sickness in the Insured Population of Scotland.

6 Ministry of Pensions and National Insurance. (1951.) Digest of Statistics analysing Certificates of Incapacity. ⁷ Scottish Home Department. (1946.) Report of the Committee

on Homeless Children. ⁶ Massey, A. (1949.) "Modern Trends in Public Health," pp. 113, 114.

⁹ SAVAGE, SIR WM. (1954.) Public Health, **68**, 74.

¹⁰ Department of Health for Scotland. (1936.) Committee on Scottish Health Services. Report, p. 45.

HEALTH EDUCATION IN PRACTICE•

By JOHN D. KERSHAW, M.D., D.P.H. Medical Officer of Health, Colchester M.B.; and Area Medical Officer, North-East Essex

Health education is essentially the means to an end, but not to a single end. There are, in fact, four principal objectives :

1. The carrying out of a single action.

2. The development of a habit.

The inculcation of a technique of healthy living. 4. The production of a favourable climate of opinion.

The first of these is a comparatively simple aim. We meet it, for example, in campaigns for vaccination and in mass radiography surveys. The essential thing is that as many people as possible shall either do a particular thing themselves or shall cause it to be done by or to their children. Once it is done, there is no need to concern ourselves with the individual for at least several years. This type of objective can be reached by short, sharp campaigns of exhortation and persuasion; it is not necessary, though in some cases it may be desirable, that the person who is being persuaded should have much-or even any-detailed knowledge of what is being done and why it is good for him.

The second, habit formation, is typified by such things as the regular cleaning of the teeth, or the washing of hands after using the toilet. Healthy habits are usually harder to acquire, because they are more laborious or inconvenient, than unhealthy ones. They cannot be produced by brief "shock" campaigns; they require prolonged effort which should, preferably, start in childhood. It is considerably easier to make someone develop a healthy habit if he is given at least a rudimentary understanding of why the habit

is healthy.

The third objective, the inculcation of a technique of healthy living, is exemplified in such things as dietetics. Though we speak of "food habits" we are really referring to something which goes beyond true habit and involves the regular making of a deliberate choice of foodstuffs. It is essential that a person who is planning a sound diet for either himself alone or for his family shall have some elementary understanding of the fundamentals of dietetics.

The fourth objective, the development of a favourable climate of opinion, is necessary because no social and legislative advances toward community health can be made in a democratic society until a substantial proportion of the people feel strongly that such advances should take place. This demands that as many people of good will and influence as possible should understand something of the principles and practice of social and preventive medicine and should be capable of transmitting some of their knowledge and understanding to others.

The various techniques of health education need to be applied deliberately with specific aims in view, method being in every case matched to sim. Unless this is done, time,

money and energy will be wasted.

General Health Education

It is not yet sufficiently realised by the powers that be that non-specific health education has an important place. Some general education is valuable, though not essential, as a first step. In Eastern countries effective elementary health education is given to the illiterate by purely pictorial techniques, but in more highly developed countries health education by the written word is important and demands literacy, while health education by the spoken word demands that the listener shall have a vocabulary. So complicated are present-day living techniques that healthy living is difficult for anyone who cannot read and write and do simple money sums.

^{*} An abridged version of a lecture delivered at the Refresher Course for Senior School Medical Officers, Birmingham, September, 1954.

Beyond this, the general education given in our schools can and should contain education toward health. The elements of human physiology and even of human ecology, elementary social history and even elementary medical history can be profitably included in the curriculum of the school without any disturbance of its balance. Lister, Pasteur and Ross, for example, are as attractive heroes for school reading-books as Drake, Marlborough and Wellington.

Outside formal education, a great deal can be achieved by conditioning the child and the adult toward healthy living; conversely, much sound health education can be neutralised by adverse conditioning. Lessons in personal hygiene are merely a bad joke in a school with inadequate washing facilities, dirty toilets, ill-kept floors and play-grounds and poor heating and ventilation. Good food habits cannot be taught if school meals present the children with unappetising and badly-cooked essential foods. In all these matters the school medical officer has a special responsibility, while the public health department has a similar task in seeing to it that the adult and the family are given, in their homes, the proper surroundings for the practice of healthy living.

Specific Health Education

It is convenient to divide the specific techniques of health education into two parts, propaganda and deliberate education.

The term "propaganda" is used here of methods which are designed to produce "shock effects," such as poster and advertising campaigns and certain films for public exhibition. Their most obvious use is in persuading people to carry out single actions; the success of the various campaigns for diphtheria immunisation is an instance. By themselves, however, these techniques have little value in inculcating healthy habits. It is important not to be misled by commercial advertisements and their undoubted effectiveness. There is no doubt that advertisement makes millions of people use "Doe's Dainty Dentifrice" in preference to other preparations, but they are people who had formed the tooth-cleaning habit beforehand; it is highly improbable that Messrs. Doe's advertisements have ever made anyone start de novo and continue the tooth-cleaning habit. Propaganda has, however, a second useful function in that it may be used to prepare groups and individuals for more deliberate education. It can produce an awareness of a topic coupled with a curiosity which will make a proportion of people listen to or read information about that topic.

The effect of propaganda is rather short-lived. It is useless, therefore, to urge people by poster and advertisement to be x-rayed or to have their children vaccinated unless x-ray and vaccination facilities are available at the time of the advertisement or immediately thereafter. Follow-up of propaganda by lectures and other forms of education ought also to begin while the shock effect is fresh. And, finally, continued propaganda techniques tend to defeat their own purpose in that the public becomes familiar with a picture or a slogan so that it makes no impression.

Deliberate health education may be by the spoken word or the written word. Of the two the former is undoubtedly the more effective and convincing if it is well done. No literary skill can ever convey to a reader quite the same sense of personal importance as can good oral instruction, and every health worker should try to acquire some skill in this latter.

Conversation

On the whole, the best type of health education is given in personal conversation. The health visitor visiting the home and the school medical officer talking to a parent at school medical inspection have excellent opportunities for this, since in each case contact is through common concern for the welfare of a child. Instruction in this way can be specific to the child or the family concerned and can be given concrete form in terms familiar to the present. No special linguistic skill is needed in the educator, but it is important that he or she should be able to express things

in simple language and should obviously mean what is being said.

Group Talks and Lectures

The aim in talking to a group must be to find common ground for all the members of the group. The larger the group, the more necessary it becomes to talk in general terms, since the specific problems of one member may mean nothing at all to other members. By the time the audience becomes really large its members may have very little in common and therefore the lecturer's talk will become too general to be worth listening to. Except in rare instances, therefore, talks and lectures are really useful only when they are given to a selected group whose members have some common interest—mothers attending a particular clinic, a parent-teacher association, a women's institute or a co-operative guild. In such cases the topic selected should be one which is related, directly or indirectly, to that common interest.

It is a common superstition that eloquence and oratory, inborn and practised, are essential to the good lecturer. In sober fact, a polished technique of delivery and a wellgroomed voice may, in this field, do more harm than good, by "depersonalising" the lecturer. The good health educator will talk in an ordinary voice without being afraid of using colloquialisms. He will eschew a platform and if a table is provided in front of his audience he will sit upon it rather than stand behind it. He must "come down off his perch" so effectively that the existence of a perch will not be noticed. Whether he speaks from notes or not is immaterial, provided that he knows his subject and arranges his ideas logically. The only important points of technique as such are that he must talk loudly enough but not too loudly and that he must not speak too quickly-technique of this order is within the range of everyone.

It is important not to try to say too much in the time; the beginner is well advised to prepare his talk in advance and then to shorten it by taking out a few of the less important points, which can be kept in reserve and used if he finds that he is running short of his expected speaking time. The danger of talking "above the audience's head" is less important than that of seeming to talk down to the audience. A lecturer who gives his audience apparent credit for rather more erudition than they actually possess will please them by the implied flattery, provided always that he avoids too much technical terminology. And so far as the construction of the lecture is concerned, the old maxim "first tell them what you're going to say, then say it and finally tell them what you're said" is still an excellent guide.

Visual Aids

Too many would-be health educators imagine that the use of a few much-publicised visual aids will make up for all manner of shortcomings in a lecturer. This is a dangerous fallacy; visual aids can help a mediocre lecturer to be good and a good one to be excellent, but they will never make a bad one good and in any case they must be intelligently used. The oldest one of all—the blackboard—is still one of the best, and every health educator should practise writing on a blackboard. The Flannelgraph is useful to the unskilful blackboard-writer, and has the extra merit of being usable to encourage the audience to participate in blackboard games. Diagrams are dangerous. They may be clear to the lecturer who prepared them but misleading to a lay audience; it is unwise to use any diagram which has not been submitted beforehand to a jury of lay friends and colleagues. Models, on the other hand, are invaluable, though their scope is obviously limited.

Film strips have no special miraculous value. They are simply a more convenient version of the old magic lantern. They can be invaluable in illustrating a talk provided that the lecturer is thoroughly familiar with the strip he is using and is ready to talk convincingly about the pictures. Now that 35-mm. cameras are common and several firms will print film strips quite cheaply from negatives, more health

departments might try making their own film strips, for the showing of pictures of places and people whom the audience know catches attention far better than pictures of the unfamiliar. Sound film strips of the type now prepared by the C.C.H.E. to state human problems for group discussion are an interesting and useful innovation, but the use of gramophone records to comment upon ordinary film strips is a lazy lecturer's subterfuge for which there is no defence.

Films also have their dangers. Used with a lecture or talk, they should be carefully selected to illustrate the points the lecturer wants to make; the attitude of "I'll get a couple of films and give some sort of a talk to round the thing off" is fatal. The good film is ideal as a basis for discussion, for it can present things in a way impossible to any lecturer who uses word of mouth only. But because it sets out to be clear it often over-simplifies the issues involved, and unless those issues are worked out in discussion afterwards the audience will go away with many wrong ideas.

Discussions

Group discussion is a comparatively new method in health education which is supplementing and often replacing talks and lectures. It is by no means easy to organise, but practice brings skill. Discussion groups should be small; the larger they become, the greater is the tendency for discussion to degenerate into question and answer or a series of set "speeches from the floor." The educator acts as a sort of combination of chairman and leader, the principal difficulty of his task being to keep the discussion in or around the topics involved without discouraging members from speaking and without expressing his own ideas so forcibly and dogmatically that he dictates the content of the discussion. There is an art of apt question and comment by which the skilled discussion leader can get the members of the group to make all his desired points for him, without his having to state them in any detail himself; this art is not hard to acquire, though the educator who is a lecturer by habit will have to learn self-control.

The golden rule for discussions is that people will discuss only things which interest them. Groups, besides being small, should be homogeneous at least in the sense of all the members being concerned with the topic or topics chosen. There is, of course, much to be gained by having members whose association with those topics is not quite all the same; the essence of discussion is the bringing out of different points of view. Films, as already mentioned, and some sound film strips can give a discussion a flying start. especially if one or two members of the group who can be trusted to be brief are primed to start the ball rolling after the film or strip has finished. Alcoholic refreshments. repeatedly proved in public-houses to be excellent lubricants for tongues reluctant in discussion, are not usually available for group discussions in health education, but coffee and tobacco and, of course, tea, are excellent substitutes. Totally dry discussions usually finish prematurely!

Sex Education

It is difficult and probably unwise to single out specific subjects for comment, but there is one which arouses so much discussion and controversy that the risk must be taken. Most of the argument as to who should give sex education, how, when and where it should be given-and even whether it should be given-is probably due to the fact that most people are either embarrassed by their own sex taboos or too conscious of the taboos of other people. There is much to be said, in theory, for its being given by the parents, but not all parents are capable of doing the job satisfactorily. It should certainly be the parents' task to give simple and sensible answers to the child's earliest questions about where he came from, but the fuller explanations which are needed for children at and approaching puberty are another matter. The intelligent child who is a good reader is not hard to help; there are several excellent books written for boys and girls of this age which can be handed to the children themselves with confidence. For most children, however, some sex education by experienced educators is desirable.

The essential purpose of sex education is to give the child basic information in such a way that he or she can begin to see sex in perspective; most difficulties and problems in matters of sex arise from failure to appreciate how it fits into the general pattern of life. To import special lecturers into school for the giving of sex education makes it at once a thing apart and defeats this essential purpose. Instruction in the physiology of sex can and should best be given as a natural part of a course of instruction in human physiology within the ordinary school curriculum, and if a special teacher is brought in, that teacher should give the whole of the physiology course. Where circumstances make it necessary or desirable that certain children should receive some individual sex education and the parents cannot give it, then the instructor should be someone already familiar to the child, such as the school medical officer or the school nurse.

Questions and Discussion

The following are among the points which were covered in the period of questions and discussion which followed the lecture:—

Specialist Health Education Officers.—These officers cannot possibly replace the S.M.O. and School Nurse as health educators, but they may be invaluable as technical advisers and they can give great help in the organisation of special exhibitions and demonstrations.

Physical Education.—Organisers and teachers in the field of physical education are important members of the health education team, especially where such matters as posture and foot health are concerned. The S.M.O. should take the utmost pains to

enlist and ensure their co-operation.

Books.—The school library and the public library should hold a stock of books which would be useful to parents and children in enlightening them on health matters. There is no reason why the school clinic should not also have a small lending library for this purpose. It would be useful if one of the journals circulating among members of the School Health Service could publish an appropriate bibliography.

MEDICAL CARE OF YOUNG PERSONS IN INDUSTRY*

By J. A. DUNCAN, M.B., CH.B.

Divisional Medical Officer, I.C.I. Ltd., Witton, Birmingham

It was in 1937 that our Medical Department first took practical steps to tackle the problem of the youngster in industry, owing to the very high labour turnover amongst the boys and girls. The reasons for this were largely wrapped up in the lack of facilities for learning a trade and the general attitude towards the young persons by both supervision and management. No sound education policy after leaving the elementary school was provided either by local authorities or by individual concerns. Of course, technical schools and evening classes were well established and a few enlightened firms did have schemes of training and education. Most youngsters, however, did not receive any further teaching after leaving school at 14. The day continuation school and the works county college were dreams. Apprenticeship schemes as we know them were rare. This was certainly true of my own organisation at that time.

There was no information service whereby the Company's policy, the prospects it offered, its amenities, educational schemes, canteens etc., could be brought to the notice of the youngster. Our labour policy was not yet developed to give the young person the chance he desired. The blindalley job—learning by picking up from older men on the job and finally the cheap labour angle—was the order of the day.

In 1937 some 178 boys and 407 girls were examined. Of these three were rejected as quite unsuitable—two having gross mittal disease and the other being an epileptic of poor mentality. In addition 22 were regarded as fit for special or modified work only—eight because of some cardiac reason, six because of poor physical development,

^{*} Paper given at the Refresher Course for Senior School Medical Officers, Birmingham.

three low intelligence, three because of some foot fault and two because of defective vision. Within a year a third of the boys and a quarter of the girls had left to try their luck elsewhere-not a situation of which to be proud.

The Medical Department, as their contribution towards solving this problem, decided to follow up these youngsters. It was arranged that each boy and girl between the age of 14 and 16 should visit the Department, every three months after the initial examination, for an interview, during which the youngster was weighed and measured, his or her physical development observed and timely advice given about remediable defects. As confidence was gained the boys or girls would often talk of their troubles, especially those within their department, which could often be smoothed over by a friendly word from the M.O. to those in charge. The boys and girls were encouraged to chat about themselves, their hobbies and pastimes, their ambitions and anxieties, as well as about their health. The medical aspect was often very secondary.

The immediate effect after the introduction of this scheme was a falling off in the labour turnover; within six months it had fallen by at least 10%, partly I am sure due to the fact that at last someone had taken a personal interest in the young person. No longer was the young lad or girl just a cog in a machine to be working but not heard.

The war brought the scheme to a halt and it was not re-introduced until 1946. Amongst the many post-war changes which have taken place in industry, was that in the attitude towards the youngster coming into industry. His place in the scheme of things is now recognised. For example, apprenticeship schemes, together with the provision of well-equipped schools, day continuation schools (or works county colleges), youth clubs, subsidised meals in the works canteen and free dental service and medical care.

Present Policy towards the Employment of Young Persons

Boys.

Practically all the boys entering our employ are taken on to the works payroll (90%). Well over 80% come in directly from school between the ages of 15 and 16. few are accepted between 17 and 18 years, primarily because boys of this age group become liable for military service just when time and effort spent in training could be expected to give some return. We draw our boys mostly from secondary modern schools but some coming in at 16 are from junior technical schools and the secondary grammar schools as direct entrants to the apprentice school.

Candidates are interviewed for employment before they leave school, in order to gain an impression of their suitability. Some are recommended to us by the Youth Employment Officer but the majority are encouraged to seek employment with us through parents, relatives and There is still a strong family spirit in the factory.

After acceptance there is a medical examination by a Company's Medical Officer. Using the provisions set out in Section 126 of the Factories Act, 1937, the Company have applied to the Factory Department for one of their Medical Officers to be the Appointed Factory Doctor with regard to the examination of young persons. In this way one examination fulfils the requirements of both the Factories Act and the Company.

Shortly after joining, each boy is given a series of tests designed to grade his intelligence. There is also an Introductory Course lasting a week to familiarise them with the Company's activities and amenities, including such subjects as pay, safety, security,

recreation etc., coupled with a factory tour.

For the first year they attend the Works County College (Day Continuation School), with reports of their progress at its end. These, with reports from their Departmental heads, are summarised. Those selected as suitable candidates for apprenticeship are also given some special tests to determine mechanical and manipulative ability.

Practically all those coming hope to become apprentices, and recruitment is largely to this end. Only a few find their way into unskilled tasks. Most of those who do not reach the required

standards leave to try to gain training elsewhere. Those selected for apprenticeship attend a six weeks trade selection course, during which time they see all the trades in the factory and have lecture demonstrations by works foremen. The interest have lecture demonstrations by works foremen. of the boy is judged by simple tests at the end of each session and at least 20% change their minds. In addition to training in the apprentice school, practical experience is gained in the factory under the direction of skilled tradesmen and time is given for study at technical schools.

There is little to say with regard to boys joining the administrative staff. About eight or so are recruited each year under the age of 18 and are mainly for the Research Department as

Laboratory assistants.

Now let us consider selection and employment of girls in the same age group. On the works payroll we find that, unlike the boys, at least three-quarters of our intake have done some work previously (Table II) and their age distribution is approximately equal in the three age groups, 15-16, 16-17, 17-18 (Table III). The youngest, aged 15-16, are engaged as messengers in the postal and other departments. At the end of a year a few specially bright ones are selected for training in shorthand and typing; the rest do simple clerical duties such as filing, book-keeping and general office work, but they still remain on the works payroll. The majority, however, do work in the various production departments.

As in the case of the boys destined for the apprentice school, girls joining the staff mainly come direct from school—85% in fact (Table II); just over half at 15-16 with about 30% at 16-17 and the rest from 17-18 (Table III).

Those arriving at 15+ come to us from secondary modern schools. After suitable intelligence tests and interview the successful ones begin as postal clerks and after three to four months are moved on to become juniors in other departments according to their particular bent, interests and suitability in other ways.

From the secondary grammar schools the intake is usually from 16-18 years. Depending chiefly upon their educational standard and suitability as determined by specially selected tests and interview, these girls are offered several openings

(a) Those with a good general certification of education or holding one of a higher grade are trained in the Secretarial Training School. From this school most of the senior secretaryships will ultimately be filled.

(b) Those who are unsuccessful in entering the Secretarial Training School are accepted as trainee typists, receiving parttime training at the school, spending the balance of their time gaining varied clerical experience within the factory.

(c) Specially suited girls, again with a good general certificate of education, may be sent to a local training school at the Company's expense, for training as calculating machine operators.

(d) Others with the necessary educational standard may be accepted as laboratory assistants. They are encouraged to attend the Central Technical College with a view to a higher qualification such as an extra mural B.Sc., London.

(e) Finally, some are appointed as clerks.

All young persons entering the factory are given an introductory course. The fifteen-year-olds from both the staff and works payroll have a joint course in the Day Continuation School. Open to all members, whether of the staff or works payroll, are the many sections of the Recreation club, e.g., Youth Club, Sports Section, Discussion and Debating Society, Gramophone Circle etc. We have even a cycle speedway!

All under 18 years of age are given subsidised meals

and for 8d. can have a meat dish with two vegetables and

pudding.

Medical Care

Under the provisions of the 1948 Factories Act, Section I, all those on the works payroll are medically examined on entry and thereafter annually up to the age of 18. I have already mentioned that the Appointed Factory Doctor for young persons is one of the Company's Medical Officers, by which arrangement we have been able to combine both the statutory medical examination and the Company's preemployment examination. There is another advantage: the Appointed Factory Doctor can, if it is thought necessary, obtain a copy of the School Medical Officer's report. The annual examinations have largely replaced the scheme of

regular reviews, which I mentioned earlier.

Because within the Company there has been a tendency to treat all young persons alike, the barrier between works and staff barely exists; they attend the same Day Continuation School, Youth Club etc.; it was advised that the form of medical supervision should be the same for both works and staff. This principle was accepted and all young persons between 15 and 18 are medically examined annually.

Our Dental Department also gives special attention to this age group. We have, too, a visiting ophthalmologist and chiropodist to help us. Besides this there is the Insustrial Health Department equipped with x-ray facilities staffed by whole-time medical officers and nurses. In various parts of the factory are four

Ambulance Rooms staffed also by nurses.

Health supervision is only one facet of the scheme for the care of young persons. There is the closest liaison between all those concerned with their health, education, training and supervision, and this has done much to make the scheme successful. When the necessity arises we are prepared to seek help and advice and information from the boys' or girls' general practitioners, from hospitals, chest clinics and Public Health Departments.

Some Records

Finally, I would like to discuss some figures which I have prepared from the record cards of the young people who have passed through our factory in the last three years.

Within the factory perimeter where I work we have, in fact, two factories. The main factory, which I have called "A," is very large, having full facilities such as I have already outlined. The other, a subsidiary, which I have called "B," is an entirely separate entity from the main factory. All the boys and girls employed in factory "B" are taken on for production work, mainly of a repetitive type such as turning, drilling, lathe and capstan work. There is no formal training or apprenticeship scheme. Although the figures of factory "B" are fairly small during the period I have chosen, a quick check back over the years with larger numbers suggests that the figures I am offering are fairly representative.

It is fair to say that in the main factory "A" we do not have a complete cross-section of the youth of this city. It is my impression that the majority of the boys on the works payroll who become apprentices and the staff youngsters are drawn from the same sort of families, mainly artisan and lower middle classes—if one can use that description these days. The intake into factory "B" and the works girls in factory "A" come to us from the families of manual workers. This idea is, I think, supported to some extent by the evidence I have prepared in my Summary of Statistics.

Population

TABLE I POPULATION

			A	В	Totals
Girls	 	Staff	205	_	205
		Works	234	46	280
Boys	 	Staff	27		27
		Works .	210	63	273
		Total	676	109	785

Although I have included the figures for boys on the staff of factory "A" they are really too small to be of significance. From Table II you will see that the majority of those taken in on the staff and the boys in factory "A" come to us directly from school. Those making a direct entry at the age of 15-16 come from secondary modern schools, while the 16-17 age group are drawn from secondary grammar and secondary technical schools. The rest, that is the girls on

Pre-employment Examination

TABLE II
PRE-EMPLOYMENT EXAMINATION

		Direct from	m School	Had pre	vious emp	oloyment
-		1 1 7	A	В	A	В
Girls	 	Staff Works	85% 24%	28%	15% 76%	72%
Boys	 	Staff Works	93% 95%	36%	7% 5%	64%

TABLE III

Age Distribution			15-	-16	16-	-17	17-18		
			A	В	A	В	A	В	
Girls	•••	Staff Works	55% 31%	55%	29% 27%	28%	16% 42%	17%	
Boys		Staff Works	88%	64%	67%	30%	33% 1%	60%	

the works payroll of both factories and the boys of factory

"B," have had other jobs before they reach us.

Regarding labour turnover, I have already indicated the differences between factories "A" and "B," although it is true to say that there is little difference between the girls in factory "A" on the works payroll and the boys and girls in factory "B." This in a way is borne out in the figures for labour turnover. (Table IV.)

TABLE IV

		Girls		Boys			
Labour turnover	Staff	Wo	rks	Staff	Wo	rks	
	A	A	В	A	A	В	
1951–53	4.9%	27%	15%	3.7%	1.9%	52%	

Where boys and girls are employed in work which gives them future prospects, and particularly where training for some chosen task, there is little movement and so the labour turnover in this group is something less than 5%. In fact, in factory "A," of the boys coming in on the works payroll in 1953, none left. On the other hand, in the case of those who are taken in for various production jobs, or those who do not manage to fulfil their ambitions, a restlessness develops, and they tend to move around from job to job trying to find their niche. This is extremely well borne out, I think, in the case of the boys of factory "B," where labour turnover is slightly above 50%.

I have noticed since the war a general improvement in the standard of physical fitness. I think nutrition is better, and at pre-employment examination the abnormalities recorded are usually of a very trivial nature and mostly remediable. It is extremely rare that a youngster is rejected and, in fact, in the period under consideration two girls were not accepted because they were one-eyed and one whose personal hygiene did not permit employment in the canteen. I believe I am right in saying that since 1946 these have been the only rejections. A small number is taken on conditionally, about 3%.

In Table V I have indicated the percentage of those who had nothing adverse recorded against them. This, too, I think is interesting, because where there is a carefully selected population, as in the case of the staff boys and girls or in the works boys who are coming to us as apprentices, about half measure up to this rather stringent standard,

whereas only about a quarter of the girls taken on the works payroll in both factories and the boys of factory "B" came into this category. In some measure I think this does suggest that there is a difference in the social status from which these two groups are drawn.

TABLE V

		Girls			Boys	
Nil abnormal recorded on Pre-employment	Staff	W	orks	Staff	Works	
examination	A	A	В	A	A	В
	43%	25%	28%	44%	45%	27%

The list of defects which I have included in Table VI is not meant to be exhaustive, but rather indicative of the sort of things which are easily recognised. Except for a very few cases there is nothing of great moment, except perhaps where visual acuity was sufficiently poor that glasses should be worn. In the majority of cases where visual acuity was below 6/9, I found that the youngster had worn glasses at school but on coming to work had discarded them. Vanity, I think, is probably the commonest reason for this.

TABLE VI

Pate non 100		Staff	Works	(Girls) Works	(Boys
Rate per 100		A	A	В	A	В
Visual Acuity:			-			
(a) 6/9 or less one or bo	th					
		15	15	22	9	20
(b) Monocular			0.8	2	1	2
0 1 1 1			-	-	1.5	5
Ears:						
(a) Wax	***	4.5	10	10	14	7
(b) Otorrhoea and perfor	a-					
tion		1	4	8	0.5	8
(c) Mastoidectomy		1	2.5		0.5	1
Enlarged tonsils		2.5		- 5	4.5	14
Defective teeth and gums		7.5	15	13	21	17
		1.5	.1.3	1	1	1
		0.5	0.4	1	0.5	-
IIi.		-	_	_	_	-
Varicocele and Hydrocele			-		0.5	1
Feet—including:		11	13.5	24	5	6
(a) Corns		1.5	.8	7	0.5	
		0.5	3.8	7	2.5	_
(c) Hammer toes		2	1.7	1	0.5	1
			3	1		2
		3.5		7	0.5	2
(f) Hyperhidrosis		1	-	-	1.5	4
Skin—including:		18	23	16	19	21
(a) Acne vulgaris		12.5	16.5	12	15	14
(b) Seborrhoea		2	2.5	2	1	1
(c) Urticaria					Marrie .	-
(d) Eczema		1		_	0.5	3
(e) Psoriasis			0.4	1	-	-
(f) Occupational		-	-	1	-	attention
Posture (scoliosis, kyphosis						
etc.)		1.5	3.4	7	1.5	5
Physique (undeveloped, po	or					
nutrition, etc.)		0.5	0.8	2	2.5	3
Nits			3.8	11	_	_

In Table VI I have expressed the findings as a percentage so that some comparison can be made between various groups in the different factories. I think that one of the most interesting observations, as I am sure you all well know, is that boys tend to have less trouble with their feet than girls. Apart from that there is no appreciable difference in their general well-being. Nits are occasionally seen but the frequency is actually decreasing, and although we show a rate of about 4 per 100 for the girls in factory "A" and 11 for the girls in factory "B," I think I am right in saying that, in fact, only one girl in both factories was seen in 1953. I have not seen scabies for quite a long time now.

Occasionally we see an early mitral stenosis—about six cases were noted out of the total of 785—and occasionally a child with what is thought to be a patent ductus arteriosus or a small ventricular defect. Lung conditions are rarely seen, although we have had one girl who came to us after a period of sanatorium treatment for tuberculosis, another girl who had had a lobectomy for bronchiectasis and one boy with asthma.

Among the conditions regarded as not being worth while including in these rates, we have seen one boy with undescended testicle, and one boy with marked gynaecomasia which disappeared completely after a year or so. Two of our girls under 18 on the works payroll who were married were found to be pregnant at their pre-employment examination, and one girl had an alopaecia capitis which required a wig. We find, too, that about 8% or 9% of girls tend to be overweight compared with about 2% of boys.

I think that the position with regard to the health of the youngsters we see can be summarised by saying that the majority of them are really quite fit and well able to fulfil the tasks they have to do. What defects we find are of little consequence and can usually be put right. The general standard of physical fitness of those coming into our industry has improved, and this surely reflects credit upon the work of the School Health Service.

BASIC ELEMENTS IN CHILD PSYCHIATRY*

By Kenneth Cameron, M.B., F.R.C.P.E., D.PSYCH. Physician, Bethlem Royal and Maudsley Hospitals, London

While the psychiatry of childhood is now an established branch of medicine it is still liable to be regarded as something of a mystery or cult not to be understood by other than initiates. For this situation some responsibility must be taken by those who are practising in the field; asserting our claims for recognition we have, in the past, emphasised the uniqueness of our special techniques rather than the ground we share with our colleagues concerned with child health; we have stressed, too, the importance of what is hidden rather than what is obvious. It is the purpose of this paper to record much that is both obvious and important to all of us responsible for the well-being of children; not to create child psychiatrists but give a broad understanding and a number of generalisations applicable to the field of child health.

First we would assert a number of truisms :-

(a) A child is a developing organism with his own potential level of development, physically, intellectually and in the sphere of feeling and personality.

(b) He is dependent on his environment and reacts to it and his reactions may in varying degree be reversible or established in his constitution and personality.

(c) He is, however, a unique individual with his personal needs and desires, his own pattern of response and his peculiar personality.

When a child presents symptoms of emotional disturbance or problems of development or behaviour, a number of questions must be answered before a diagnosis may be made and treatment decided upon.

In the aspect of potential and development we must discover whether this child is genetically endowed to meet the demands of the environment and further whether any factors are interfering with this capacity. Put more simply, there are the questions of whether he is physically normal and healthy, intellectually of normal intelligence and emotionally not suffering from severe deviation of personality.

Physical handicapping and ill-health in their grosser forms are obvious to all and need little emphasis. We do, on the whole, make provision for the deaf, the blind, the severely ill, and life has been modified for them to allow of their meeting its demands and pursuing their own purposes. In child psychiatry, however, one is impressed with the importance of minor handicapping or ill-health in adding to the stresses borne by the individual. Slight impairment of vision, a squint, the need to wear spectacles, minor degrees of deafness; slight physical handicaps that diminish capacity for games or impair looks; lowered physical health; each of these may contribute to the child's failure to adapt without symptoms. In child psychiatry physical examination

^{*} Address to the Refresher Course for Senior School Medical Officers, Birmingham.

and investigation is made not to exclude but to include the

hysical factor.

Equally, we know what provisions should be made for those who suffer from grosser intellectual handicap, though we recognise how deficient this provision is both for the ineducable and the educable. We are coming to realise, too, how they may be helped to achieve and make their individual contribution. Minor degrees of variation often within the limits of the normal may, however, put the child out of step with his peers and play a part in symptomatic disturbance. Furthermore, specific disability or ability in one or other aspect of intelligence may, if unrecognised, create a problem. Relative word blindness or failure to recognise or reproduce symbols is not uncommon and the intelligent child educationally backward as a result may suffer more acutely than the dull and backward. Here it is appropriate to emphasise the importance not only of reliable intelligence testing but also of investigation of educational level. The child may have an intelligence level appropriate to his age and class but if ill-health, changes of school or other difficulties have resulted in two or three years' retardation in reading or arithmetic he may be confronted with failure for four or five hours of every school day. And we must make some response to failure-by devaluation of the field in which it occurs—"he just doesn't care" or by evasion or compensation—"he just sits and dreams" or plays the buffoon."

To present the aspects of the individual symmetrically one should speak of normal emotional endowment and factors that may handicap. In our uncertainty, however, as to what emotional norms may be, it is enough to say that they are wide and to counteract the impression created by too much emphasis on the child's reactivity, that the great variation in the sensibility and responsiveness of children is due

solely to the environment.

That children are different every parent and teacher will recognise. In respect of emotional handicapping actual abnormality is rare. Degrees of reactivity may vary. One child may be more vulnerable than another. It is in the realm of feeling, too, that the child reflects most readily his earlier experience.

The Child's Reactions to Environment

Turning from the child seen as a developing organism with intercurrent factors that have affected him in the past, the present situation is assessed by considering him as reacting to his environment. Here two questions are for answer.

First, are his normal needs being provided for? The material needs of childhood are familiar but can only be ignored if adequate. The less tangible needs of childhood are met in normal home life. What these needs are has become explicit through the study of disturbed or deprived children. Briefly, these needs are for love and security; the incentive to conformity that comes from a fundamental desire on the part of the child to keep the approval of those who give him love and security; stimulus and outlet appropriate to the child's developing capacities; a reasonable framework of authority within which their needs are met.

The second question is whether the demands of the environment are appropriate to the capacities of the child. We have already considered whether the child's capacities are normal. But the variations within the normal in physique, intellectual capacity and emotional stability are wide and in addition parents, teachers, the community generally may be making unreasonable demands or demands which the child cannot meet. Sometimes these demands are obvious if looked for. Sometimes they lie hid in the personalities of parents who see in their children the possibility of success in fields closed to the parent. Sometimes they represent social phenomena; in some groups the over-valuation of the white collar persists.

The formulation of the environment in terms of how the child's need are met and what demands are made upon him, whilst an appropriate frame of reference must not, however, cloud recognition that the environment is largely people and

the child also a person, and that needs are met and decisions made on the basis of personal relationships.

The first of these people is the mother. Normally she is a constant and reliable figure in the child's environment. She loves him and values him for his own sake, irrespective of merit or deserving. This initially provides him with a warm welcoming environment, an encouragement to face the world. To it he responds with a desire to conform, to retain her approval. Motivation for domestic conformity derives from this need to retain the approval of the loving parent. Equally the father provides a secure figure on whom the child may unquestioningly depend to secure his needs, with whom he counts; one on whom he may in varying degrees model himself. Given this security and trust of parents the child develops confidence in himself and it is what they value and approve that is good to the child. Their disapproval, bans and prohibitions signify what is wrong and forbidden. The child may err, but eventually their values give a background to his standards. This only obtains, however, if the basic relationship of love and trust exists. Without it the child is left at the mercy of instincts and impulses, or in a state of only superficial conformity that breaks down when out of observation or control. Without it, too, it is less easy for the child to find in other adults what is to be admired and emulated, and the alternative figures life provides may bear the brunt of resentments and rebellion primarily directed to those who owned his security. (The "difficult phase" often seen in children apparently ideally placed depends on this "working out." It requires patience but passes.)

Parents must, however, appreciate, too, the child's need for physical play and creative activity and recognise what degree of social conformity and level of behaviour is appropriate to his age and development. Undue restriction or demands can operate adversely in a good basic relationship to abnormal inhibitions or untoward outlets, and symptoms

may eventuate.

Given, however, parental love and valuation of the child, reasonable approval, stimulus and outlet, a normal framework of authority also contributes to the child's security. This is important; those who deal with children are often afraid to exercise reasonable authority and control appropriate to the child's age and state. The ultimate aim is to cultivate responsibility and decision in the child but this is not achieved by abrogating reasonable authority in childhood. What is impossible is to substitute an excess of authority for deficiencies in security, approval and outlets.

The Child in Terms of "Socialisation"

Having considered the child's endowment, what has happened up to the time of investigation and to what he has reacted and is reacting, one must assess the actual individual child and what his pattern of response may be.

Conveniently the child may be seen in terms of socialisation. The first 18 months to two years has been termed the age of primary socialisation. In this stage of development the infant matures his sensorial equipment and organises his perceptions. He gains motor control and elaborates external communication in speech. In this period, too, and in the succeeding phase of, from two to four or five that of domestic socialisation, adaptation takes place. Eating, sleeping, elimination, and motor activity subject to social restrictions and modification gradually fall into a pattern of conformity in the home, in fact fall into a highly organised pattern differing widely from the impulsive gratification of the infant. Personal relationships, too, become modified. The dependence of the infant and the aggressive, self-seeking of the individual merge ideally into a responsive affectionate independence,

During these phases of development, if the child is of normal endowment and physical health and material needs are met, environmental disturbance usually means a failure in the attitudes that should bring the child through these phases of adaptation. Lack of security in the parents means lack of confidence in the child and results in a fearful anxious infant with unsettled functioning. The norms of habit

formation are wide for the individual and the social group, but persistent or widespread disturbances in one of the functions of eating, sleeping, elimination or motor activity, points to a failure in these maternal or parental influences. With this is usually associated disturbance in personal relationships—undue dependence or aggressiveness, or both,

temper tantrums, jealousy, etc.

Frequently, too, there is an excess of gratification habits, thumb sucking, rocking, genital play, etc. The latter suggests a lack of warmth in the environment and the child who is turning into himself for pleasure and comfort. In the older child daydreaming to excess is a sequel. Tension habits, nail biting, picking, hair pulling, etc., to excess equally suggest that the environmental influences—i.e., parental attitudes are too restrictive or inhibiting—the child's normal aggressive drives find insufficient outlet and become turned in on himself. Minor tics, grimacing and frequently encopresis suggest more serious degrees of over restriction.

The normal developing child probably at some time or other shows gratification or tension habits, but it is where established and persistent in association with manifestly disturbed personal relationships and habit formation that

they become symptoms.

With school age the child enters into the phase of community socialisation. Home influences remain most important but many other figures divide the role that has been taken by adult figures in the home and play their part in shaping personality. Ideally the school entrant, trusting, confident, responsive and independent is ready to utilise the new figures in his environment. Adults admired or trusted become figures to be emulated. Secure in his unique position in his own family circle he can find his level with his peers. He can respond to the new challenge of adult and contemporary who are not so prepared to value him unquestioningly but to whom he must justify himself by his

personality, behaviour and achievement.

This makes in some ways greater demands on him-it is at this stage of his life that failure to achieve legitimate merit in school or in the playground may create a situation of stress for him. During these years he strives to value himself on the basis of others' valuation. This requires that both teacher and contemporary appreciate what he is and does. It is during this period that minor handicappings are of great significance. The situation within the home, however, remains of primary importance. The child may come to the school years with the incomplete adjustments of the pre-school years, he may seek compensation in school and playground for what he has lacked at home. Indeed, he may find it and the school years provide a solution. The warmhearted kindergarten teacher provides something that has been missed; the absence of an adequate male figure in the home may be met by master or older boy; the lack of opportunities in the restricted urban home by outlets provided at school; the child lacking in a sense of being valued or more superficially from too much criticism finds esteem among his fellows or in class. The risk lies in whom he finds this esteem. It is no use grumbling at the boy who seeks unsuitable companions if they provide what he seeks in vain from his proper environment. Or later on to condemn the girl who finds at long last she does have a social value-however transient.

The happy result is not inevitable. The child unduly dependent may retreat and become isolated or less obviously retreat from his peers and seek to find all compensation in achievement in class. He is liable at puberty to find that his escape has not worked. The false adaptation to school leads to unbalance and anxiety at puberty. The "good" boy develops anxieties and fears and won't go to school, or rather won't leave home. Equally, as indicated, the child who has not found security in personal relationships at home may fail to accept the values of the undervaluing parents and slide into delinquency. Or less serious, a home basically sound but with over high standards may produce a child erupting into mischief of greater or less consequence through

Symptomatically, most stressful situations produce anxiety in the child which may show itself in nervousness, fears, disturbances in sleep or somatic symptoms, in addition, perhaps, to the range

lack of normal outlets.

of symptomatology previously discussed. There is yet to be considered the individual reactions on a wider scale. These may be capable of formulation in terms of adult psychiatry. While minor somatic symptoms are frequent in children in association with emotional upset, organised hysterical symptoms are uncommon. They are very often superimposed on an organic disability or otherwise mean a relatively severe personality disturbance. Equally, psychic or somatic expressions of anxiety are frequent, but a recognisable anxiety state is not often found before puberty. Minor obsessionalism may appear in early childhood but the positive obsessional illness is rare and serious. Psychotic illness in the absence of organic brain damage is relatively infrequent but by no means a rarity. Children who have epileptic manifestations are not rare, nor are those who carry the effects of brain damage from birth, encephalitis or flead injury. Only if severe do they dominate the picture. It is astonishing how much careful handling of them and their environment may do to dissipate symptoms often regarded as inevitable correlates of the organic state. It cannot too often be emphasised that these cases are often of excellent prognosis.

Treatment

Treatment is a wide subject and only a few generalisations may be made. Much of it follows from assessment of the problem. Difficulties due to minor handicaps may often be met if they are appreciated, remedied, or the environment appropriately modified. A human appreciation of the parents' point of view and difficulties must precede any effort to modify attitudes. Condemnation is a luxury of one's private life. Professionally it is damaging. Mothers always feel the fault is theirs. If their child falls short in any way complaints and abuse of the child, of the school or even the examining doctor is a mask behind which lurks doubt and self-criticism. They are always anxious and receive little comfort from a doctor who does not listen to their fears or examine carefully and assess before reassuring. Fathers are important people and frequently valuable allies if their confidence and point of view is sought. Teachers have been rendered almost as insecure as parents and often want reassurance almost as badly. A human approach to the child and an endeavour to appreciate a difficult world from his angle may give relief, comfort and support that can allow him to cope.

If the symptoms are creating undue stress in home or school, if the cause is not obvious and remediable on inspection of the whole situation, if the child is suffering, or the pattern of disturbance not modifiable by obvious approaches, the help of the child psychiatric clinic should be sought. There the irvestigation may be more thorough, assessment of the problem based on more information and greater experience, the skills by which parents are helped to modify attitudes more developed, and the therapeutic approach one that calls for an elaborated understanding of personality and deploys its own techniques. But psychiatry provides no alternative to humanity and good sense. It provides wide knowledge and its own skill but must pay due regard to

what is obvious.

If the clinic does not provide an assessment of the situation or guidance in plain terms that will help those who are dealing with the child, or if treating the situation it fails to maintain diplomatic relations with the other people concerned, it should be written to, telephoned and called upon till it does.

The British Tuberculosis Association.—The Hon. Secretary regrets to announce that in circumstances outside the control of the Association the progress report on the M.R.C. trials of BCG and Vole Bacillus Vaccines announced for the session of the Annual Conference at Cambridge in the afternoon of June 29th cannot now be given. Medical officers of health are however, cordially invited to attend the opening meeting of the conference at 2.15 p.m., on Tuesday, June 28th, in the School of Zoology, Downing Street, when there will be a discussion on "Migration and Tuberculosis" opened by Dr. Norman Macdonald (Clare Hall), Dr. Michael Flynn (Co. Westmeath), and Dr. J. Farrell (Co. Roscommon), and the meeting on Thursday, June 30th, at 11.15 a.m., when Dr. J. C. R. Buchanan (Colonia! Office), and Prof. F. R. G. Heaf (University of Wales), will speak on "Tuberculosis as a Problem of Preventive and Social Medicine in Overseas Countries."

DISTRICT NURSING RECORDS*

The Objective

(1) The objective of the Committee's deliberation has been to ensure that District Nursing records shall attain a uniform minimum standard designed to provide a clear picture of the types of patients and illnesses treated by the nurses and, by a review of this picture, of changes in the quantity and quality of the demand made upon the service. By implication such a statistical picture would itself constitute morbidity information which, though crude, might prove to be valuable to Medical Officers of Health especially if such information could be integrated with other morbidity

(2) In order to provide these statistics it is essential that there should be a record card summarising each completed spell of treatment. By classification of such cards, an analysis could be made of the clinical and social features of

local nursing activity.
(3) It would be desirable that the classification and counting of the cards together with any associated coding of treatment or diagnosis should be carried out at a central office where skilled clerical labour and mechanical aids (such as punched card installations) would be available. If this ideal could be attained the nurse would be relieved as far as possible of a clerical duty which she may be forgiven for regarding as a burden and as an obstruction to her primary task of nursing sick people.

(4) Unfortunately, it is only in highly compact areas that such centralisation is possible and only in very large towns that clerical labour and punched cards can be provided centrally. In very many cases there will be no proper evaluation of the importance of the work of the district nurse unless she is prepared to produce the necessary

statistics herself.

(5) The Sub-Committee have therefore sought to devise a record card which, limited in content to the irreducible minimum, is logical in arrangement and is self-classifying to an extent which facilitates the preparation of statistics by manual counting. With such a card it is confidently hoped that the nurse will not find it too difficult or time-consuming to make her own statistical survey.

The Record Card

(6) The following particulars are to be recorded on the card, which will not be fully recorded until treatment is regarded as complete in the sense that a continuous series of visits has terminated and will not be resumed except on the invitation of the patient and/or the medical attendant :-

Dates of first and last visits.—These dates provide the means of calculating the duration of treatment. (See "days on books" below.) Only cards on which the date of last visit falls within the period under review will be included in the current statistical

analysis of cases.

Name, sex, age.—These particulars are required partly for entification. Sex and age are important characteristics in identification.

relation to any clinical classification.

Case referred by .- The source of demand is an important fact in relation not only to the proper regulation of the flow of work, but also in relation to the co-ordination of the district nursing service with hospitals, general practitioners and other services. Enter "G.P.", "Hospital," "Chest Clinic," "M.O.H." or Direct Application."

Name of doctor in attendance.-It is necessary to identify the medical practitioner under whose direction nursing treatment is being given. This information does make it possible, if necessary, to bring together the records of patients who are on the list of

the same practitioner.

Disease under treatment.—The main preoccupation, for statistical purposes, should be with the disease from which the need for nursing care has originated. If the nurse has been primarily called in to dress an injury or a varicose ulcer she may be immediately aware that the patient is suffering from other disabilities, e.g., heart disease or bronchitis. It is, however, to be presumed that though these accessory conditions will trouble the patient they will not call for nursing care, and that such care is primarily required only for the injury or varicose ulcer or whatever is cited as the immediate need. There may, however, be instances where a minor disability, e.g., abrasion from a fall is merely the precipitating event in bringing a major disability (e.g., cardiac insufficiency) under nursing care. The nurse should in the latter case select, as the disease under treatment the major disability if, when the abrasion has been treated, the reason for the fall remains as a need for further attendance. After entering the diagnosis, add the appropriate group number from the attached list, e.g., "Cerebral haemorrhage".= 8, "Diabetic gangrene" = 6.

Other diseases or disability.—This provides for the recording of

diseases which do not constitute the fundamental reason for reference for nursing treatment. These conditions are certainly important in qualifying the individual case and they may occasionally form the basis of valuable supplementary analyses. The same

code numbers can be used as for the principal condition.

Incontinence.—It is necessary only to encircle the appropriate number, viz., (1), when the patient is regarded as having acquired the status of urinary or faecal incontinence, i.e., when the condition, though perhaps only occasional, has emerged as a continuous liability.

Assistance available.—Information of the availability of help from relatives, friends, or home help is essential to the proper determination of need not only in relation to the amount of nursing service but in relation to whether hospital treatment may be preferable to domiciliary care. Encircle the appropriate category, viz., (home help).

Occupation (state if retired).-To the extent to which the records are suitable for morbidity measurement it will be necessary to consider whether particular diseases are more prevalent in those who have followed certain occupations; it will be pertinent also to regard the (former) occupations as an index of general social conditions in considering what other resources may be available for the care of the patient. Enter information as fully

as is available without unduly pressing the enquiry.

Nursing treatment.—Sufficient detail should be inserted on the card to permit the addition of the code number from the appended Since it is implicit that some general nursing is involved in the more specific forms of treatment listed it is not necessary to state "general nursing only" unless in fact none of the other listed treatments has been administered. If more than one of the specific treatments has been given, e.g., injection I, and dressing, 4, both should be recorded. (It is recognised that the number of treatments will be greater than the number of patients.)

Number of days on books.—This is obtained from the dates given

at the head of the card.

Number of visits.—It is important to be able to measure the frequency of visits for different types of disease in order to plan the nursing service efficiently. Enter the total number of visits over the entire duration of treatment.

Reason for completion.—It is merely necessary to encircle the appropriate reason for withdrawing the service.

Reference to other District Nursing Record.—It may be important to be able to consult the records of previous spells of treatment and a space has been provided on the card for such a cross reference.

Name of Nurse.—The record card is a valid, personal and confidential medical record. It should bear the signature of the person responsible for the compilation, so that direct reference can be made in the event of there being any doubt in interpretation.

Briefly, the following information regarding the patient should appear on the Record Card.

Information re Patient
Date of First Visit Date of last visit
Name Sex Age
Address(District Code No.)
Case Referred by
Name of Doctor in Attendance
Disease under Treatment(See Appendix A)
Other Diseases or Disability
Incontinence, 1, Urinary Faecal
Domestic Assistance available. Family/Home Help/Other
Occupation (State if retired)
Nursing Treatment (See Appendix B) No. of Visits
Reason for completionDied/Admitted to Hospital/Left
District. Name of Nurse

APPENDIX "A" Home Nursing Statistics Classification of Diseases

Tuberculosis.

2. Other infectious diseases, Including: Common childhood fevers (measles, etc.), food poisoning, dysentery, venereal diseases, erysipelas, poliomyelitis, herpes zoster (shingles).

^{*} A Memorandum on the Use of a Proposed District Nursing Record Card, prepared by a special Committee and adopted by he Council of the Society on May 13th, 1955.

Excluding: Influenza, pneumonia, gastro-enteritis.

3. Parasitic diseases.

Including : Worms, scabies, pediculosis.
Malignant and Lymphatic Neoplasms,

Including: Cancer, sarcoma, malignant growth, epithelioma, rodent ulcer, leukaemia, Hodgkin's disease.

5. Asthma.

Diabetes mellitus,

Including: Complications, e.g., gangrene, cataract, etc.

Vascular lesions affecting the Central Nervous System, Including: Subarachnoid haemorrhage, cerebral haemor-hage, embolism, or thrombosis; recent hemiplegia (less than a year), apoplexy, stroke.

9. Other mental and nervous diseases,

Including: Psychosis, melancholia, senile dementia, psychoneurosis, neurosis, anxiety, alcoholism, drug addiction, mental deficiency, disseminated sclerosis, paralysis agitans, spastic paralysis, long-standing hemiplegia, epilepsy, progressive muscular atrophy, neuralgia, neuritis, sciatica.

10. Diseases of the Eye.

Diseases of the Ear.

12. Diseases of the Heart and Arteries,

Including: Acute rheumatic fever, heart disease (except congenital, No. 26); high blood pressure, arteriosclerosis. gangrene (except diabetic, No. 6).

13. Diseases of the Veins,
Including: Varicose Veins, varicose ulcer, haemorrhoids,
thrombophlebitis, phlebitis.

14. Upper Respiratory Diseases

Including: Common cold, acute sinusitis, acute tonsillitis, influenza.

Other Respiratory Diseases, Including: Pneumonia, bronchitis, empyema, pleurisy (except tuberculous, No. 1), congestion of lung, bronchi-

Excluding: Tuberculosis (No. 1), and cancer of lung (No. 4)

16. Constipation.

17. Other diseases of the Digestive System,

Including: Disorders of teeth, tongue and mouth, gastric, duodenal and peptic ulcer, gastritis, appendicitis, hernia, intestinal obstruction, gastro-enteritis, fissure in ano, cirrhosis of liver, cholecystitis, gall-stones.

18. Diseases of the Urinary System and Male Genital Organs,

Including: Nephritis, calculus, cystitis, stricture, enlarged prostate;

Excluding: (Retention of unstated cause, No. 25).

19. Diseases of the Breast and Female Genital Organs,
Including: Salpingitis, boil of vulva, vaginitis, uterine prolapse, disorders of menstruation, leukorrhoea. Excluding: Growths and cysts (cancer, No. 4, benign growths, No. 25).

20. Complications of Pregnancy and the Puerperium,

Including: Abortion, post-partum mastitis. 21. Diseases of Skin and Subcutaneous Tissues,

Including: Boil, carbuncle, cellulitis, whitlow, acute

lymphadenitis, impetigo, dermatitis, pruritus.

22. Diseases of Bones, Joints and Muscles,
Including: Arthritis, rheumatism (except acute rheumatic fever or rheumatic heart disease, No. 12), fibrositis, myalgia, osteomyelitis, prolapsed invertebral disc, synovitis.
23. Injuries.

24. Senility,
Including: Old age.
Excluding: Senile dementia, psychosis or confusion

25. Other defined and ill-defined diseases or disabilities.

26. Diseases not specified.

APPENDIX "B"

List of Treatments

Injections.

9 Blanket baths.

3. Enemas.

Dressings. 4.

Changing of pessaries. 5.

Washouts, douches, catheterisation, etc. 6.

General nursing care.

Attendance at minor operations.

9 Preparation for diagnostic investigation.

10. Other.

THE ORGANISATION OF AN OCCUPATIONAL **HEALTH SERVICE***

(1) In 1949the Government set up a Committee "to examine the relationship between the preventive and curative health services provided for the population at large and the industrial health services which make a call on medical manpower (doctors, nurses and auxiliary medical personnel); to consider what measures should be taken by the Government and the other parties concerned to ensure that such medical manpower is used to the best advantage; and to make

recommendations.'

(2) The Society submitted both written and oral evidence to the Committee, subsequently known as the Dale Committee. The report of this Committee, published in February, 1951, referred (para. 44) as follows: "We think that consideration should be given to the possibility of some adjustment being made with the view to the experience of Medical Officers of Health being more extensively used in preventive medicine," and in their recommendations referred to the necessity of co-ordination between the National Health Services, Public Health Services and the Industrial Health Services (paragraphs 67); to the desirability of some comprehensive provision for Occupational Health covering not only industrial establishments of all kinds, both large and small, but also the non-industrial occupations referred to in the Gowers Report (paragraph 69); and, in order to co-ordinate the development of an Industrial Health Service fully and effectively with the general health services, the need for the formation of a Standing Joint Advisory Committee with strong medical representation (paragraph 75).

(3) Since the Dale Committee reported, the Government has announced the establishment of an Industrial Health Advisory Committee (November 11th, 1954) and since the Gowers Committee reported consideration has been given to the health and welfare of workers in non-industrial establishments, etc., and the Society has submitted evidence in relation to the proposed new legislation. It is noted that the proposed legislation generally places the responsibility for the enforcement locally of the legislation on local authorities. The Minister of Labour in his statement to the House of Commons on November 11th, 1954, stated that he had now decided to take steps to stimulate the further development of industrial health services in work places covered by

the Factory Acts.

The Society is well aware of excellent organisations set up by certain large industrial undertakings, both nationalised and private, but is equally conscious of the lack of any service on a national scale covering in particular smaller undertakings, though attempts have been made in a variety of ways to try and fill this need.

The Medical Officer of Health and His Present Relationship with Industrial and Other Undertakings

(4) A great many services exist to-day which, while they do not come within the category of occupational health services, are closely related to such a conception and have an influence on the health of the worker in industry. At the present time the medical officer of health, functioning in one or other of his various capacities, is closely concerned with the position of the individual in relation to his employment in the following ways. (a) School Health Service.—Periodic medical inspections,

together with a great variety of special inspections associated with individual illness or handicap are carried out on all school children and these medical records are available to the appointed factory doctor for his medical examinations carried out under the Factories

An assessment of the school leaver's ability to undertake employment is supplied to Youth Employment Officers. Medical records are available in respect of handicapped children, their training and placing in industry.

A report by the Occupational Health Committee, Society of Medical Officers of Health, adopted by the Council on May 13th for submission to the Ministers of Labour and Health.

(b) Mental Health Service, -Active supervision of mental defectives in domiciliary care is carried out, including collaboration with the Disablement Rehabilitation Officer, for the placing of suitable persons in industry. Under the National Health Service Acts, some Local Authorities are establishing industrial training centres with a view to the subsequent employment of such persons in open industry or in sheltered occupations.

Increasing advice is available to the Ministry of Labour and its staff in relation to the employment of persons suffering from mental disorders and under the supervision of the Mental Health

(c) Tuberculosis.—The Care and After-care Services of Local puthorities assist in the rehabilitation and training of tuberculous Aersons at sheltered workshops, e.g., Enham Alamein, Papworth, Barrow Moor Hall colonies, and some authorities maintain their own rehabilitation centres and colonies for tuberculous persons.

The M.O.H. has laid on him important duties and responsibilities in regard to the employment of tuberculous persons particularly in respect of the character and conditions of employ-

(d) Handicapped Persons.—Where the Medical Officer of Health carries out duties under the National Assistance Act, he is actively engaged, and collaborates closely with the D.R.O., in the rehabilitation and subsequent employment in open industry

or in sheltered occupation of the blind, deaf, crippled and epileptic.

(e) Prevention and Control of Epidemic Illness.—The Medical Officer of Health is actively concerned with the occurrence of epidemic illness in the community including that resulting from the ingestion of infected food, whether in factory or other place of employment, and in the control of such illness.

(f) Atmospheric Conditions.—He is actively engaged in measures designed to control pollution from the atmosphere from

all undertakings, with the exception of a few prescribed industries.

(g) Rodent Infestation.—The control of rodent infestation is normally carried out through the medium of the public health

(h) Supervision of Out Workers.—He is concerned with the

conditions of employment of out workers.

(i) Supervision of Certain Manufactured Articles. - The Medical Officer of Health issues certificates of warranty in respect of certain articles manufactured in his area, e.g., brushes, cheese cloths, rag flock, etc. For this purpose he is required to be actively cognisant of the conditions under which manufacture is being carried out.

(j) Health Education.—Health education is an increasingly important function of the medical officer of health and from time to time industrial concerns seek his advice and assistance, par-ticularly in relation to such problems as venereal disease, tuber-

culosis, hygiene of the toilet and spitting.

(k) General Hygiene.—The Medical Officer of Health is involved in the supervision of many factories undertaking work which may impinge on the health of the general community, e.g., bottle washing and filling—where food stuffs and beverages are concerned, sweets and confectionery preparation, ice-cream, etc., offensive trades.

(1) Specific Duties under Factories Act.—The enforcement of the provisions in relation to sanitary conveniences in all factories and those in relation to cleanliness, overcrowding, temperature, ventilation and drainage of floors in respect of factories in which mechanical power is not used, comes within the ambit of the

medical officer of health.

It will be seen from the evidence given above that the Medical Officer of Health is already playing an appreciable part indirectly in the supervision of the health of workers and, therefore, in the development of an occupational health service, which logically demands his active co-operation and association in all parts of the service in which he is a specialist.

The Development of a National Service

(5) The Society is of the opinion, as it was when it submitted evidence to the Dale Committee that fundamentally an occupational health service should form part of the National Health Service but if it is to develop on separate lines it is essential that close interlinking of the existing services with the new should be achieved.

(6) The nature of the link that could be achieved centrally between the government departments concerned is one primarily for those departments but the Society is satisfied that at the periphery the best service can be achieved and the most comprehensive links forged by the development of

a service as now outlined.

- (7) There are not yet precise limits to the concept of an occupational health service and the extent of the service can vary not only as between the essential needs of different occupations but also in the competitive desires of sections of both management and labour within the same occupation groups. Any service to be established should provide the means for seeing that an over-all minimal standard is achieved without restricting the legitimate aims of those who might want to provide medico-social services of wider scope than is absolutely necessary.
- (8) The physical environment in which men and women are employed no less than that in which they spend the rest of their lives should be such that it is not conducive to the production of sickness and a proper standard of hygiene should be maintained. The supervision of the sanitary environment has long been the province of the Medical Officer of Health and the relative absence of much disease to-day is directly associated with the development of preventive hygiene in the past 100 years. There is still great scope in this field of activity as, for example, in the handling of foodstuffs, in the control of tuberculosis, poliomyelitis, visual defects, osteoarthritic lesions and so on. It is considered that the supervision and control of the sanitary environment in all workplaces including heating, lighting, ventilation, drainage and closet accommodation, washing facilities and overcrowding, should be a function of the Medical Officer of Health in his capacity as an officer with statutory responsibilities.
- (9) In the comprehensive field envisaged in the term occupational health service it is clear that wide variations exist from fully developed services to none at all. Where undertakings have already established satisfactory health services in the light of existing experience and knowledge these should be maintained in their existing form. In the development of a new service to cover those vast sections of the working population whose needs are not at present met and particularly those employed in the smaller industrial units and in commercial and other undertakings where specialised and highly technical chemico-physical problems do not arise, the Society is of the opinion that the best form of peripheral organisation would entail the establishment of a medical team composed of a medical officer experienced in preventive health work and local general practitioners each functioning in his particular field.
- (10) The great mass of illness occurring amongst workers is of an everyday character and is not specific to the particular occupation. There is much need for relating the past history of the individual as it is known through school health records and the existing family environment as it is known to the M.O.H. and the family doctor with his employment conditions in industry. A Medical Officer of Health is well fitted for carrying out investigations into occupational morbidity and hazard, for handling special problems relating to the married woman, the aged and the handicapped and for propagating the principles of health education and is in a unique position to provide liaison with the other statutory services and with his colleagues in other branches of the profession. He would in effect function as the medical inspector of factories in his area. The general practitioner is equipped to carry out medical examinations of entrants to industry, of workers exhibiting reaction to their conditions of employment, etc., and to supervise the therapeutic services provided. He would function as a clinician and in his own right carry out medical examinations and advise on treatment where appropriate to an occupational health set up.
- (11) Such a team would work in association where necessary with whatever lay inspectorate may be provided to deal with the technical industrial problems appropriate to their functions. It is considered that a central laboratory service is necessary to the running of a successful occupational health service and that the peripheral medical team would stand in relation to it as they stand in relation to the laboratory services provided under the National Health Service Acts.

(12) A scheme devised on the lines indicated at the periphery would, with the most economical use of medical manpower, bring to the service of the work the doctors best equipped by their training, experience and knowledge of local conditions and would provide the most efficient link with the related local services. It would enable managements who are desirous of maintaining private services so to do and it would form a unit working in direct association with whatever central organisation is devised to oversee the national pattern.

THE PLACE OF THE MEDICAL OFFICER OF HEALTH IN RESEARCH*

In considering the place of the Medical Officer of Health in research, and the functions of the Research Committee itself, two matters are involved in addition to the primary issue: (a) a consideration of what should properly be regarded as research; (b) the research actually undertaken by executive public health departments in recent years and

the factors which have determined its volume.

For convenience in drafting and because most of the problems considered concern the Medical Officer of Health, we have referred in most places in the report only to the M.O.H. and the local health department. It should, however, be understood that like problems arise for medical officers in the Services and central government departments and for Departmental Medical Officers in local government, many of whom are members of the Society. With suitable modifications in wording our observations apply to them equally.

Investigation a Part of the M.O.H.'s Ordinary Duties

It is an accepted part of the M.O.H.'s duty to inform himself about a wide range of problems related to health and disease in his area. For this purpose he makes investigations of one sort or another almost without intermission. Such investigations afford a good indication of the M.O.H.'s field of specialisation, but cannot as a rule be classed as research.

No hard and fast line can be drawn between the ordinary investigations carried out by every M.O.H. and research proper, but a number of practical tests can be applied.

Broadly, investigations undertaken by the M.O.H. as a public health practitioner have implications which tend to be local rather than general. They tend to be concerned rather with immediate practical problems of administration than with more fundamental or long-term objectives, and they are not intended primarily to add to the existing body of systematised knowledge. As a rule these investigations are published only in reports intended primarily for the M.O.H.'s own Authority. Point for point, researches proper have converse characteristics.

The distinction is important because investigations and enquiries not amounting to research can usually be planned and undertaken without any question of outside help or special authorisation by the local authority concerned. Such investigations, which constitute the great bulk of investigations by local health departments, are consequently unlikely

to concern the Society's Research Committee.

Types of Research

There is nothing to preclude the M.O.H. from taking part in research in any field of medicine, but in practice he is in present circumstances less likely to undertake researches based on specialised laboratory techniques than to pursue studies in the field. The direct investigation of physical factors affecting health and disease—e.g., problems of bacteriology, virology, applied physiology and experimental psychology—usually requires well-equipped laboratories and specialised techniques no longer provided within the framework of health departments in Britain.

Investigations into such matters as air pollution, the heating and ventilation of dwellings, and sanitary procedures, still provide fruitful fields of enquiry and have perhaps been unduly neglected in recent years. Without underestimating their importance, however, it seems clear that the M.O.H.'s unique area of research is the community in its total setting.

Some researches in this field have objectives which are primarily administrative. They include :--

- (1) The assessment of medical care and social needs.
- 2) So-called operational investigations.

(3) Evaluative investigations.

Examples of investigations under each of these headings will readily occur to anyone familiar with present-day public health and welfare services. The assessment of medical care and social needs includes for instance such familiar problems as the medical and nursing supervision of the sick child, and the special needs of handicapped persons and the aged and infirm. The expression "operational investigations' refers particularly to studies designed to measure the efficiency of existing services such, for instance, as studies of the way in which home nursing services, home help services. infant welfare services or day nurseries are being used. Evaluative investigations include particularly field trials, such as the recent whooping cough immunisation trials and the controlled trials of antigens against poliomyelitis now in progress in the U.S.A. They include also investigations with a more administrative flavour such, for instance, as studies to measure the efficacy of a health educational or publicity campaign, or the value of such procedures as routine school medical inspection, health visiting for this or that purpose, or the routine use of medical staff in infant welfare work.

To some extent the classification is arbitrary, but it is useful for distinguishing important sectors of research which are of special interest to executive health departments.

Often investigations in these classes are a natural part fo the M.O.H.'s ordinary duties, but in their more elaborate

forms they can be regarded as true research.

Other investigations within the province of public health are clearly deliberate research projects, embracing on the one hand investigations of an anthropometric nature and on the other, enquiries into the mass aspects of health and disease. Some of the investigations in these groups have for their objective to state the incidence or prevalence of particular diseases or disabilities in a particular age group or segment of the population. Others, commonly subsumed under the heading of epidemiological studies, seek to elucidate aetiological questions by discovering the environmental associations of disease. It will not escape attention that the complete ascertainment of conditions in local communities often requires that clinical data must be made available by medical care services in the area, e.g., General Practitioners and Medical Staffs of the Regional Hospital Boards.

All the investigations mentioned depend on field surveys at some point, and usually involve the use of statistical methods. It is in these areas that the M.O.H. can most obviously make a special contribution to medical or social-medical research—and this is equally true whether the M.O.H. is working alone or in collaboration with others. It is obviously advantageous if the M.O.H. had a recognised status in the medical care services.

The various investigations undertaken by the M.Os.H. and the staffs of health departments can also be distinguished for the present purpose according to their alternative modes of origin—i.e.:—

(1) Projects initiated within the local health department itself.*

A report by the Research Committee, Society of Medical Officers of Health, adopted by the Council of the Society on May 13th, 1955.

M.Os.H. are not infrequently asked by a colleague, often another M.O.H. who is undertaking an investigation in his own area, to follow up families who have moved. We have not given work of this kind a separate heading, but we recognise its value and importance

(2) Projects which owe their inception to central authorities, permanent or ad hoc research bodies, or to other bodies

of a national or regional character.

(3) The Committee can assist officers who initiate research by approaching suitable bodies to invite their collaboration with the Society or its members. Whilst the Committee would like to play an active part in the conduct of enquiries in the field, because of the lack of adequate facilities it is quite impossible to do so.

(4) The Committee's main function will be to act as a clearing house-i.e., it is a suitable body for scrutinising and co-ordinating requests for help by M.Os.H. in the conduct of investigations initiated by national or other bodies. This applies especially when the collaboration of several medical officers in different parts of the country is solicited.

We are satisfied that the Committee has already proved

useful in this way.

(5) As a rule, there would be no advantage in involving the Committee when a research project requires collaboration between an academic department or other body and one M.O.H. only. The Committee could, however, be the more useful generally if it were kept informed of any such

(6) We do not think the Committee can do much directly to stimulate an increase in the volume of research coming out of local health departments. They might, however, do

so indirectly in several ways :-

(a) By forging links between the public health service on the one hand and academic departments and the

general practitioner service on the other.

We think, for instance, that a representative of the College of General Practitioners should be invited to serve on the Research Committee and also that it should be suggested to the College that they might consider the nomination of a member of the public health service to their local faculties.

(b) By encouraging M.Os.H. to provide opportunities for M.Os. in health departments to undertake longterm studies. This would not only add to the prestige of the public health service but would give an added

interest to the work of the Assistant M.O.

(c) By drawing the attention of those concerned to the difficulties and obstacles referred to earlier in our

report, and to any arising in the future.

(7) Finally, we repeat that although the Committee can help medical officers in the ways we have suggested, no Committee can provide a substitute for individual initiative. This applies with equal force to research projects in which the health department is associated with other bodies, such as Service Departments, The Ministry of National Insurance. general practitioners and so forth.

So far as enquiries initiated locally are concerned, the M.O.H. should suggest lines of research to medical officers in his Department, encourage them to pursue investigations and help with their planning. To do these things should be regarded as a natural extension of the M.O.H.'s primary

Organisation of the Research Committee's Work

We make the following suggestions which we think should be taken into account in organising the Committee's work.

(1) The Committee as at present constituted is, in our view, too big to meet regularly for the purpose of dealing with purely routine enquiries.

(2) It should meet—as required—to receive reports and

to discuss matters of general policy.

(3) It would be an advantage to appoint a small Advisory Panel consisting of, say, three or four members, to whom the Medical Secretary could refer questions, either indivitually or collectively as the occasion arose.

(4) The Secretariat of the Society should deal with routine enquiries and maintain records of projects brought

to its attention.

(5) The report finally approved by the Council should be publicised to members of the Society and to University Departments. It would be an advantage if the co-operation of University Departments on the basis of the report could be invited by the President acting with the authority of the

Projects requiring investigation on a nation-wide scale and projects for investigating differences between representative areas in different parts of the country also almost inevitably

fall into the second category.

We recall here that the Research Committee was originally set up because of the large number of requests for assistance that were received from the organisers of research projects, and it was considered that large-scale enquiries which needed the help of Public Health Departments, should be actively co-sponsored by the Society.

A review of the enquiries considered by the Research Committee since its appointment in 1951 shows that most of the problems referred to it fall under the second heading above, i.e., instructed by outside bodies. They have

included :-

(a) Poliomyelitis and Inoculations—referred by Ministry of Health and M.R.C.

(b) Infant Morbidity and Mortality-referred by the Department of Preventive Medicine, Welsh National School. (c) Child Development—referred by Joint Committee, Population Investigation Committee and Institute of Child

(d) The Future of Child Welfare Clinics-referred by M.C.W. Group.

(e) The Effects of Work during Pregnancy-referred by National Birthday Trust Fund. (f) Retrolental Fibroplasia-referred by Ministry of

(g) Other: Survey of Illegitimate Children, District Nursing Records, Contamination of Bathing Beaches, A Cancer Enquiry, Milkless Babies and Breast Cancer.

Research Activities of Local Health Authorities in Recent Years

Although a great many local investigations are always in progress, the small volume of research work published in

recent years requires explaining.

The situation should be viewed first of all against a background of wider changes. Social-medical research was running at an unusually high level in the immediate post-war period and especially at the time the Society's Committee was established. Since then the volume has assumed more modest, but probably more normal proportions. development of academic departments of social medicine and social science at many Universities and extensions of the research activities of the General Register Office and the Medical Research Council in post-war years have also tended to limit the area of independent investigations open to local health departments. The operation of these factors is not, however, the whole explanation.

Research requires a combination of vision, will and means, which has apparently been relatively less common in public health departments during the post-war period, than in earlier years. All true research involves the vision to see what is needed, the will to pursue distant objectives and access to the instruments and facilities appropriate to the task in hand. Younger members of the service may require assistance in preparing the results of their work in suitable

form for publication. It cannot be expected that more than a fraction of doctors in any branch of medicine will have the personal qualities and the opportunities needed to initiate elaborate investigations and carry them to completion. For a number of reasons the present period is probably one of unusual difficulty in the public health field. Since the National Health Service Act became operative the M.O.H. has not had access to clinical data in many fields where such data was previously available to him.

A generation ago the M.O.H. had a training in sanitary and laboratory sciences which matched the outstanding problems of the time. The important unsolved problems now facing the M.O.H. require a different technical training

-an expertness in the use of statistical methods, field survey techniques and the analytical procedures underlying human genetic theory. These subjects have not had a prominent place in D.P.H. courses for more than a few years, and in consequence not every senior man in the ranks of public health is practised in their use as research tools. It is the case, moreover, that no more than a handful of local health departments yet employ the services of a statistical officer, or deploy the mechanical devices for coding, counting and sorting operations which are needed for large-scale enquiries.

Instances of Local Authorities failing to support the M.O.H. wishing to undertake research must be rare. None has been brought to our notice, nor have we any evidence that financial obstacles have affected the situation to any considerable extent. For most of the research work initiated within the department the M.O.H. usually has access to the resources he needs without the question of additional expenditure arising. (We except from this statement the provision of a suitably equipped statistical section to which

we referred earlier.)

The tendency for academic departments and research bodies to appoint persons to permanent or long-term posts to supervise or conduct research has, we think, been another factor contributing to the decline in the volume of researches initiated in local health departments. It is a factor which operates in two ways. It tends to deny the necessary postdiploma experience to men who will enter the executive services, and increases the risk of field research becoming to be regarded as the exclusive business of the whole-time specialist. Any staffing arrangements which would facilitate interchange between academic and executive fields would clearly be beneficial. We think also that more M.Os.H. would be likely to undertake research work if the diploma courses indicated to a greater extent than at present the gaps in knowledge which local health departments might help to close ...

Finally, we would stress that successful large-scale investigations in the field often require at some stage the collaboration of academic departments or research institutes.

The M.O.H., like his colleagues in other branches of medicine, has in the past tended to an individualism which is sometimes out of keeping with the requirements of the modern world. It should be realised that most investigations initiated and conducted exclusively by a local health department in isolation cannot be more than pilot enquiries, important as they are. It is only rarely that elaborate investigations can be planned and undertaken without team-work of a high order and the right links to ensure this have not yet been forged in more than a few areas. These also are facts which any realistic appraisal of the present status of the local health department in research must take into

Functions of the Research Committee

We are now in a position to suggest what the Advisory Committee can be expected to do and what it cannot hope

First of all we wish to state that our re-examination of the Committee's functions and a review of the work it has done since its inception in 1951 has satisfied us on three points :

(1) The Committee's aims as originally declared are fundamentally sound.

(2) The Committee has in fact served the purposes intended.

(3) So far as we can foresee, its future role will not be greatly dissimilar from the role it has already fulfilled. We have reached the following particular conclusions

about the Committee's functions :-

(1) Though it can often render valuable help in ways mentioned later, the Committee cannot in our view initiate research or play an active part in the conduct of enquiries and investigations. Neither can it, without incurring implied



PURE SPARKLING WATER

Free from Bacilli or other deleterious organisms. Used by Allied Armies and Air Forces for drinking water. Continuous operation.

Cleaning is simple takes only a few per hour-larger minutes.



METAFILTRATION

THE METAFILTRATION COMPANY LIMITED. BELGRAVE ROAD, HOUNSLOW, MIDDLESEX

HOUNSLOW 1121/2/3 GRAMS: METAFILTER, HOUNSLOW



responsibilities which will be difficult to discharge, make specific suggestions to individuals for research or encourage individuals to undertake research work.

The Society of Medical Officers of Health has neither the

staff nor the resources to undertake these activities.

(2) Only in a limited sense can the Committee advise individual medical officers about investigations initiated by them. It cannot proffer technical advice, but it can advise them about investigations known to be going on elsewhereand thus help avoid needless duplication. In some instances, it can offer general guidance on ways and means. It might also sometimes be instrumental in putting an individual medical officer of health in touch with a person or an institution which is able to give assistance of a technical nature.

THE MAY COUNCIL MEETING

(Concluded from page 130).

supervision of the conduct of the visiting parents

would be necessary.

(c) The wearing of protective clothing by visitors and the application to them of the routine measures for the prevention of the spread of infection which are applicable to nursing staff engaged in cubicle nursing. This would necessarily include the proper use of adequate ablution facilities.

(d) The visitation of some cases of infectious disease should not be permitted at all, e.g., smallpox and some types of cases of intestinal infection.

(e) Visiting should be limited in general to parents and guardians, and children of school age or under should not be permitted to visit, except in very exceptional circumstances.

4. It is considered essential that the ultimate decision on the question of permitting visits by relatives must depend on the individual circumstances in relation to each patient in infectious diseases hospitals and must remain with the medical officers of the hospital.

The possible risk of a visitor becoming a carrier and taking the infection to other children at home (e.g., diphtheria, scarlet fever, poliomyelitis) must be fully considered in relation to the individual home and family circumstances.

Food and Drugs Amendment Act, 1954.—The Council endorsed the action of the General Purposes Committee in deciding to make no comment on the proposals of the Ministry of Food regarding (a) the Mineral Oil in Food Order, and (b) Butter, Margarine and Margarine Cheese Regulations.

The Ministry proposed, under (a) to recommend an amendment to the Order so that the requirements should not include chewing compounds which had not more than 12.5% of microcrystalline wax of a statutory specification of purity. The proposals, under (b), had been drawn up after consideration of representations by interested bodies,

including the Society of Medical Officers of Health.

Centenary Year President.—The Council then dealt formally with the question of the election of a President for the Centenary Year of the Society. Only one nomination had been received, namely, that of Dr. Charles F. White, Medical Officer of Health of the City of London, by the Metropolitan Branch supported by all other Branches and Groups. In accordance with the Articles of Association, therefore, Dr. Charles White's name was forwarded to the Ordinary Meeting following for formal election.

Election of Officers.—The following other officers for the Session 1955-56 were elected:—

Chairman of Council.-Dr. C. Metcalfe Brown. Three Vice-Presidents.—Dr. J. M. Gibson, Dr. Andrew Topping and Dr. Jean M. Mackintosh. Honorary Treasurer .- Dr. C. E. E. Herington.

B.M.A. Public Health Committee. - The Council appointed Drs. Llywelyn Roberts and H. M. Cohen as its representatives to serve on the Public Health Committee of the B.M.A. for the ensuing year.

National Medical Manpower Committee. - It was resolved that Dr. H. D. Chalke be nominated for membership of the National Medical Manpower Committee for the ensuing

Food Hygiene.—The Council considered the announcement of the Ministry of Agriculture, Fisheries and Food, that they had appointed a Food Hygiene Advisory Council. Its membership would provide that 11 members would represent the public, three the trades, and three the workers in the trades. It appeared that there was no intention to appoint a representative to express a medical or technical opinion. It was agreed that a letter be addressed to the Minister in this connection, in support of action already taken by the British Medical Association.

Recruitment to Medical Profession.—The Council appointed the President, Chairman of Council, Chairman of General Purposes Committee and Professor C. Fraser Brockington a Committee to prepare evidence for the Committee set up by the Ministry of Health: "To estimate, on a long-term basis and with due regard to all relevant considerations, the number of medical practitioners likely to be engaged in all branches of the profession in the future, and the consequential intake of medical students required."

Refresher Courses for Midwives .- A letter was received from the Royal College of Midwives referring to the fact that the Refresher Courses arranged by the Royal College had been approved by the Board to meet the requirements of the Board that attendance at refresher courses by midwives would be compulsory after December 31st, 1957.

It was resolved that the Royal College of Midwives be informed that the Society was quite confident that the courses arranged by them would meet the needs of midwives and did not wish to offer advice or suggestions at this stage.

The Editor regrets that pressure on space necessitates the holding over of the report of the Ordinary Meeting of the Society of May 13th and of a number of reports of Branch and Group Meeting

The Medical Whitley Council Committee C has issued M.D.C. Circular No. 24 dated June 1st, 1955, to all local authorities. It accepts the recent Award by the Industrial Court, and recommends that it be put into effect as from January 1st, 1955. It also deals with scales for Deputy M.O.H.s and Divisional or Area M.O.s.

SOCIETY OF MEDICAL OFFICERS OF HEALTH Medical Secretary

The Society of Medical Officers of Health invite applications r the post of Medical Secretary (part-time). The salary for the post of Medical Secretary (part-time). The salary offered is within the scale £750 to £1,000. Applications endorsed "Medical Secretary," and containing full details of the applicant's profesional career should be forwarded to the undersigned, and must be received not later than July 1st.

MEDICAL SECRETARY.

Society of Medical Officers of Health.

Tavistock House South, Tavistock Square, W.C.I.

MEDICAL RESEARCH COUNCIL

Require a medically-qualified man or woman, about 30 years of age, for work in their headquarters office concerned with administrative aspects of research. Organizing ability and clarity of expression in speech and writing are desirable qualities, and some resarch experience, although not essential, would be an advantage. Salary £1,285 (linked with age 30) rising to £2,100. Possibility of promotion to higher posts. Superannuation—F.S.S.U. Appointment probationary for two years; if probation served satisfactorily appointment will be permanent.—Apply by letter (full details education, experience and names and addresses of two or more professional referees) to Establishment Officer of the Council, 38, Old Queen Street, Westminster, S.W.I.



A single supplement for safer pregnancy

PREGNAVITE

Pregnavite provides in a single preparation a comprehensive range of vitamins and minerals essential to maternal well-being. It represents an effective—and economical—dietary supplement for the maintenance of full health throughout pregnancy and to guard against such complications as toxaemia, hypochromic anaemia, dental caries and inability to breast feed.

2 Tablets (one of each colour) 3 times a day provide:

LIQ. VITAMIN A CONG., B.P. (40 mg.) 2,000 i.u. LIQ. VITAMIN D CONG., B.P. (30 mg.) 300 i.u. VITAMIN B,, B.P. 0.6 mg. VITAMIN C, B.P. 20 mg. TOCOPH. ACET., B.P.C. (Vilamin E) 1 mg. NICOTINAMIDE, B.P. 25 mg. FERR. SULPH. EXSIC, B.P. 204 mg. CALC. PHOSPH., B.P. 480 mg. not less than 40 p.p.m. CUPR. SULPH., B.P. not less than 40 p.p.m. MANG. SULPH., B.P.C. at time of manufacture In packs of 60 and 120 tablets.

Dispensing packs of 1,000.

Basic Price to N.H.S, 1,000 tablets 32/9

Other preparations for vitamin supplementation include:-

BEMAX

Stabilized wheat germ (Plain or Chocolate)

The richest natural vitamin-protein-minera supplement, with a reliable content of B group vitamins, 27 per cent protein, 2.7 mg, iron per ounce, low sodium and low fibre. Easily digested and suitable for use in all bland diets.





VITAVEL SYRUP

Vitamins A, B1, C and D with liquid glucose

Vitamins A, B₁, C and D with liquid glucose in an orange base. No taste of fish or suggesting oil. Very low in calorific value. Suitable for patients of all ages without risk of digestive disturbance.

Basic Price \ 6 ft. ozs. . . . 2/6 to N.H.S, \ 40 ft. ozs. . . 16/-





An Ideal Weaning Food for Busy Mothers

Bovril Brand Weaning Food is in powder form and is marketed in small cubes. From a cube, a soft, digestible purée can be made in one minute. As only enough for one purée at a time is prepared, there is no waste and no risk of food infection.

Bovril Brand Weaning Food is extremely nourishing. It is composed of potato, lean beef, vegetables, yeast, meat extract, bone calcium phosphate, salt and iron ammonium citrate.

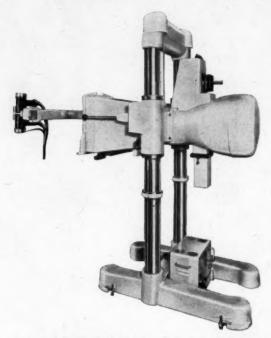
Mrs. Holt, of Bethnal Green, London, is typical of the busy mothers who buy Bovril Brand Weaning Food. She has her husband, her father and sixmonth-old baby to look after. She likes the Weaning Food for its ease of preparation and for its remarkable economy.

Bovril Brand Weaning Food is made in four varieties:

MIXED VEGETABLE · SPRING CABBAGE
CARROT · TOMATO



Better-than-ever results with WATSON-ODELCA CAMERA UNIT



A recent refinement of the Bouwer's concentric mirror system in the form of a "cone" lens, results in radiographs with even better definition and greater brilliance than ever before.

The system is embodied in a range of WATSON-ODELCA camera units for 70 or 100 mm, film and suitable for a wide variety of applications including MASS RADIOGRAPHY, GROUP RADIOGRAPHY ANGIOGRAPHY AND TOMOGRAPHY.

The illustration shows WATSON-ODELCA 100 a model specially designed for GROUP RADIOGRAPHY using 100 mm, cut film. It is equally convenient for the occasional single radiograph or small numbers as the films can be developed singly or in batches.

Processing is carried out in the ordinary X-ray darkroom using standard tanks. Most important of all, however, is the quality of the results which are everywhere acknowledged to be superb.

We will gladly send full information on request.



WATSON & SONS (Electro-Medical) LTD.

Makers of Britain's Mass Radiography Equipment

EAST LANE · NORTH WEMBLEY · MIDDLESEX

Telephone: ARNOLD 6215

What should it cost you to wash

60,000 square feet

of grubby paintwork?



How much detergent would you have to buy to clean that lot? With TEEPOL, one 4-gallon can would be enough. And the cost would work out at about 125 sq. ft. for 1d., such is the astonishing amount of cleaning power you obtain from TEEPOL. TEEPOL will take care of all your cleaning-right through the premises, and at the sink for dish-washing. Quicker, more thorough, demanding less labour, TEEPOL is safe for every surface on which you would use water.

A cost-cutter too: TEEPOL cuts expenditure on cleaning aids to the lowest possible level.



cleans just about everything!

Why not order a trial quantity from any of the following Distributors:



Black, Taylor & Cowell Ltd., Pelton Fell, near Chester-le-Street, Co. Durham.

SHELL CHEMICALS LIMITED

Burton, Son and Sanders, Ltd., Waddington House, West Hill, Wandsworth, London, S.W.18. 82 Fazeley Street, Birmingham 5.

Deodor-X Company of England Ltd., Cromwell Road, Ellesmere Port, Cheshire.

J. Evershed & Son Ltd., Dolphin House, Dolphin Road, Shoreham-by-Sea, Sussex.

Puragene Products Ltd.,

Hygiene House, George Street, Summertown, Oxford

Sposs Products Ltd.,

10 Sovereign Street, Leeds 1. Stephenson Clarke Ltd., 59 St. Mary Axe, London, E.C.3.

Union Chemical & Antiseptic Co., Muirhall Road, Larbert, Stirlingshire. Suffling Road, Great Yarmouth.

"TEEPOL" is a Registered Trade Mark

Really effective treatment for THREADWORM and ROUNDWORM

'Antepar', the original piperazine elixir, issued as a result of investigations at The Wellcome Laboratories of Tropical Medicine, is already established as a most effective and safe treatment for oxyuriasis.

Trials since undertaken by Wellcome Foundation workers have now demonstrated that in ascariasis a cure rate of more than 90% can be achieved with a single-dose treatment. No side-effects were observed.

'Antepar' is pleasantly flavoured and readily acceptable to small children. It contains piperazine citrate equivalent to 500 mgm. piperazine per fluid drachm, and is available in bottles of 4 fl. oz. and 20 fl. oz.

- Outstanding efficacy
- Rapid and complete cure
- No important side-effects
- Simply administered
- Pleasantly flavoured
- No special routine needed







ELIXIR





BURROUGHS WELLCOME & CO. (The Wellcome Foundation Ltd.) LONDON

ASSOCIATED HOUSES: NEW YORK . MONTREAL . SYDNEY . CAPE TOWN . BUMBAY . BUENOS AIRES . CAIRO . DUBLIN . AUCKLAND